Supreme Court, U.S.
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88-1376

No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

ROBERT L. MUSTO, *et al.*,
Petitioners,

vs.

AMERICAN GENERAL CORPORATION, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the
United States Court of Appeals for the Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Whether, by adoption of ERISA, Congress stripped retirees their pre-existing right to enforce a unilateral contract for tiree medical insurance.

Whether well established rules of construction for non-RISA insurance plans should be applied to ERISA insurance lans.

PARTIES TO THE PROCEEDINGS

he Petitioners were the appellees before the United States rt of Appeals for the Sixth Circuit and plaintiffs at the ict court. The named petitioners are Robert L. Musto, A. Tenison, Jr., Mildred Chandler, Clyde Bell, Thomas Gates, ner Cowherd, Charles McCharen, and H. L. Cagle. They esent a certified class of approximately 2,000 retired loyees of National Life & Accident Insurance Co. ("Na- al Life") and its predecessors or affiliated companies. The certification, as amended, states:

> Subclass A consists of all those retirees who left active employment prior to January 1, 1984, and the surviving spouses of deceased retirees (retiring prior to January 1, 1984) who were covered under the NLT/NLA plan on June 30, 1984. Subclass B consists of all those retirees who, after December 30, 1983 but before July 1, 1984, had either (i) retired, or (ii) qualified for and requested retirement, and the surviving spouses of any such retirees.

) — A-81.

merican General Corporation is the successor to National . The other named respondents are The Restated American eral Retirement Plan, The American General Early Retire- t Plan, The American General Normal Retiree Medical , the American General Personnel Administration Commit- Andrew Delaney, Harold Hook, and Darrell Olges. They employees and committees of American General and of loyee benefits plans maintained by American General and ubsidiaries.

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PETITION FOR A WRIT OF CERTIORARI

Robert L. Musto, *et al.*, and the class which they represent (collectively "the Retirees") respectfully request that a writ of certiorari be issued to review the judgment of the United States Court of Appeals for the Sixth Circuit. That judgment involved significant questions under the Employee Retirement Income Security Act of 1974 ("ERISA"): Whether by adoption of ERISA, Congress stripped retirees of their preexisting right to enforce a unilateral contract for retiree medical insurance, and whether well established rules of construction for non-ERISA insurance plans should be applied to ERISA insurance plans.

OPINIONS BELOW

ıe opinion of the United States District Court for the Mid-District of Tennessee (A-33 — A-77), which granted the ees' motion for a preliminary injunction, is reported at 615 upp. 1483 (M.D. Tenn. 1985). The opinion of the United s District Court for the Middle District of Tennessee, ı amended the definition of the class, is included as Appen-. A-78 — A-84. The opinion of the United States Court of eals for the Sixth Circuit (A-1 — A-33), which reversed the ct court, is reported at 861 F.2d 897 (6th Cir. 1988).

JURISDICTION

e judgment of the court of appeals was entered on mber 15, 1988. The jurisdiction of this Court is invoked ant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

tion 10 of ERISA, 29 U.S.C. § 1001 (A-78 — A-79), sets the congressional findings and declaration of policy in rt of ERISA.

tion 402(a)(1) of ERISA, 29 U.S.C. § 1102(a)(1) (A-80), es that employee benefit plans be maintained pursuant to ten instrument.

STATEMENT OF THE CASE

ginning in the mid-1940s, National Life[1] offered its oyees a program of retirement benefits that included al insurance. Medical insurance was provided to

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[1] Unless clarity demands otherwise, "Respondents" will be used in nce to American General Corporation, the other named ndents and National Life, the legal predecessor of American al.

ees up to a stated lifetime benefit amount,[2] and the com-
aid for it. A-41. This benefit was used by the
dents to encourage employees to stay with the
dents and forego other jobs that offered higher im-
e compensation. A-37. Respondents made regular, fre-
eference to the retirement medical insurance benefit and
the Retirees that the benefit would be at no cost to the
s. *See* A-36 — A-39 (describing promises by Respondent
edical insurance would be provided at no cost).

her documents, Respondents asserted the right to amend
ntinue retiree medical insurance in the future. However,
dents never claimed the right to reduce the benefits of
ees who had already retired. Indeed, none of the
s in over forty years of providing retirement benefits ever
the benefits given to those employees who had accepted
dents' offer by working for Respondents until retire-
See A-36. Any reductions were prospective only. No
ever suffered a reduction from the level of benefits that
ne had received at retirement.

ican General purchased National Life in November,
A-42. In 1984, Respondents reduced the Retirees'
insurance benefits and required the Retirees to make
n contributions. A-43 — A-46. Respondents ter-
the insurance for Retirees who were unable to pay the
d premium contributions. For many Retirees, the con-
ns were more than the pension they received.

Retirees filed this action in the United States Court for
dle District of Tennessee on May 2, 1985, alleging viola-

trary to the Respondents' claims of crushing, unforeseeable
s, the coverage at issue is sufficiently restricted to allow effec-
ning.

tion of ERISA.[3] The district court held a four-day evidentiary hearing and, at the conclusion of that hearing, granted the Retirees a preliminary injuction prohibiting Respondents from increasing the Retirees' premium contributions. *See* Appendix B. This grant of injunctive relief was reversed by the Sixth Circuit.[4]

The Sixth Circuit determined that as a matter of law Respondents were not required to continue the retiree medical insurance program: Because ERISA does not require vesting of welfare plans, an employer may change or terminate those plans at any time for any reason no matter what the reasonable expectations of the Retirees.

REASONS FOR GRANTING THE WRIT

The Sixth Circuit's interpretation of ERISA is contrary to the well-established rules of construction for non-ERISA insurance plans and contracts. The effect of this interpretation is to upset the settled, reasonable expectations of the Retirees and to transform the shield for senior citizens fashioned by Congress into a sword for employers fashioned by the courts. Because both the retired population and the costs of medical care are increasing, this Court should grant the writ of certiorari and settle whether ERISA allows employers to avoid otherwise binding contractual obligations to retirees.

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[3] Jurisdiction in the federal courts was alleged and is proper under 29 U.S.C. § 1132 which gives federal courts jurisdiction over ERISA issues, under 28 U.S.C. § 1331, and under 28 U.S.C. § 1332.

[4] Because the Sixth Circuit has determined the merits of the litigation, this case is ripe for review by the Court. The Sixth Circuit did not consider any aspect of the case except "likelihood of success on the merits." None of the other equitable considerations for injunctive relief intrudes.

Pre-ERISA law established that retirees, situated as are those in this case, had legally enforceable rights to the benefits promised to them. Although ERISA provides substantial statutory guidance for pension plans, Congress left it to the courts to answer the many questions ERISA does not answer about welfare benefit plans.[5] The Sixth Circuit's conclusion was that the reasonable expectations of retirees who had traded years of service for a promise of retirement insurance benefits were defeated by the "written instrument" provision of ERISA. 29 U.S.C. § 1102. This result is in derogation of the rights that employees had before ERISA was passed, is not mandated by ERISA, and is contrary to the intent of ERISA.

The extent to which retiree medical insurance is protected by ERISA is an issue that affects many, many American workers, retirees, and their employers or past employers. The average age of this country's population is rapidly increasing; more people are reaching retirement age. Medical science has extended life expectancy. Advances in medical technology have led to greater expense for medical care; more retired persons are living longer at a higher medical cost.

The Washington Bureau Group on Health, amicus curiae to the Sixth Circuit, reports that most large employers provide medical insurance coverage for retired workers. Thus, the scope of ERISA protection for this medical insurance coverage is of transcending importance to millions of individuals who have worked for large employers until retirement and who have relied on the promises of insurance for their retirement years. This issue and the question presented warrant plenary and dispositive review by this Court so that retirees can determine whether ERISA has indeed replaced their planned reliance on a retirement benefit with an unforeseen reliance on the public fisc.

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[5] Retiree medical insurance plans are welfare benefit plans as the term is used in ERISA. 29 U.S.C. § 1002(1).

ARGUMENT

I. ABSENT ERISA, THE LAW GOVERNING RETIREE BENEFIT PLANS WOULD PROHIBIT THE RESPONDENTS FROM REDUCING THE RETIREES' MEDICAL INSURANCE.

The doctrine of unilateral contract was applicable to retiree benefit plans before ERISA was adopted.[6] In *Hoefel v. Atlas Tacks Corp.*, 581 F.2d 1 (1st Cir. 1978), *cert. denied*, 440 U.S. 913 (1979), the court found that an offer of retirement benefits to be given to employees who worked for a company until retirement was an offer for a binding unilateral contract. The *Hoefel* court cited cases from ten jurisdictions for the proposition.[7] In addition to the cases cited by *Hoefel*, other jurisdictions have reached the same conclusion. *See, e.g., Melin v. Northwestern Bell Tel. Co.*, 226 N.W.2d 183 (Minn. 1983); *Schlosser v. Allis-Chalmers Corp.*, 271 N.W.2d 879, 889-90 (Wis. 1978); *Simmons v. Hitt*, 546 S.W.2d 587 (Tenn. App.), *cert. denied, id.* (Tenn. 1976). Application of unilateral contract doctrine to retirement benefits was an entrenched part of the common law when Congress adopted ERISA.

---

[6] Respondents have relied heavily on the post-ERISA distinction between pension and welfare plans. That distinction is not relevant to the state of pre-ERISA law. With the 1974 adoption of ERISA, Congress created a distinction between pension and welfare plans. The distinction did not exist at common law, but Congress found that additional protections, beyond those of common law, were needed for pension plans. *See Duchow v. New York State Teamsters Conf. Pension and Retirement Fund*, 691 F.2d 74, 78 (2d Cir. 1982), *cert. denied*, 461 U.S. 918 (1983) (Congress intended to augment not replace existing rights).

[7] The *Hoefel* court located only one contrary decision: *Boase v. Lee Rubber & Tire Corp.*, 437 F.2d 527 (3d Cir. 1970) (applying New York law). The *Hoefel* court rejected the *Boase* view as inappropriately treating retirement benefits as mere gratuities. 581 F.2d at 6. The Court in this case need not go even that far. *Boase* was explicitly premised on one crucial fact: the employer had gone out of business. 437 F.2d at 528, 532 n.n. 1 & 12. In this case American General is not only in business, but is earning record profits.

The effect of a reserved right to alter or discontinue group insurance was equally well settled. Even the Sixth Circuit held that, in a non-ERISA context, a reserved right could not exercised after retirement. *See In re Erie Lackawanna Ry. Co.*, 548 F.2d 612 (6th Cir. 1977). ERISA is the only significant difference between *Erie Lackawanna* and this case.[8]

In *Erie Lackawanna* the employer's retiree booklets stated that the "company reserves the right to terminate the plan." 548 F.2d at 626. The retiree booklets also stated that "final interpretation of any specific provision is governed by the master policies." *Id.* The master policies provided that the "policy may be modified from time to time by agreement of the [insurer] and the Employer without the consent of Employees covered hereunder . . . ." *Id.* at 626. The Sixth Circuit held that these factors did not give the employer the right to terminate the insurance of those employees who had already retired. The court stated:

Efforts by the Respondents to locate any additional contrary authority have been fruitless. None of the "contrary" cases deal with attempts to modify a retiree insurance plan after retirement. *See Cassedy v. Connecticut Gen. Life Ins. Co.*, 60 Misc. 2d 720, 304 N.Y.S. 2d 142 (N.Y. App. Div. 1969) (per curiam), *rev'g*, Misc. 2d 970, 290 N.Y.S. 2d 837 (N.Y. Sup. Ct. 1968) (change in medical coverage during employment); *Blue Cross-Blue Shield v. Jackson*, 42 Ala. App. 594, 172 So. 2d 804 (1965) (employer changed insurance carriers; employee had no right to recover from both carriers on same claim); *Fagan v. John Hancock Mut. Life Ins. Co.*, 200 F. Supp. 142 (D. Kan. 1961) (change in post-retirement life insurance benefits effected before employee's retirement).

[8] The *Erie Lackawanna* decision was based on the Regional Rail Reorganization Act of 1973, 45 U.S.C. § 701 et seq. 548 F.2d at 625. *But see In re White Farm Equip. Co*, 788 F.2d 1186, 1192 (6th Cir. 1986) (court indicated that *Erie Lackawanna* had been based on state law). Regardless of whether state or federal law is applied, the underlying principles of unilateral contract are the same.

> [T]he ... retirees devoted years of service to the [employer] in expectation that their group insurance coverage would be continued during retirement.
>
> . . . .
>
> Clearly, under our economic system, an employer cannot offer a retirement system as an inducement to employment and, after an employee has accepted employment under such circumstances, withdraw or terminate the program after an employee has complied with all the conditions entitling him to retirement rights thereunder.

548 F.2d at 626, 627.

Application of the *Erie Lackawanna* holding would have necessarily resulted in a Sixth Circuit ruling for the Retirees. However, while this case was pending before the Sixth Circuit, that court held that ERISA discredited *Erie Lackawanna*. *In re White Farm Equip. Co.*, 788 F.2d 1186, 1192 (6th Cir. 1986). In *White Farm*, the Sixth Circuit concluded that following the enactment of ERISA an employer could terminate retiree benefits after the retiree had done everything required to earn the benefits.

The Sixth Circuit's rationale for reversing its *Erie Lackawanna* decision was based on § 402(a)(1) of ERISA, a procedural provision which requires that benefit plans be maintained pursuant to a written instrument. 29 U.S.C. § 1102(a)(1). The court of appeals observed that the legislative history of § 402(a)(1) provided that "[a] written plan is to be required in order that every employee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan." H.R. Rep. No. 1280, 93d Cong. 2d Sess., *reprinted in*, 1974 U.S. Code Cong. & Admin. News 5077, 5077. The court of appeals then concluded that, because the plan reserved the right to change or terminate the plan, all plan participants should have understood that changes and terminations could take place even after retirement.

The fallacy of this conclusion is that, by reading the plan document and by applying basic contract law, including the *Erie Lackawanna* decision, the Retirees would have concluded that the plan could not be changed or terminated after retirement.[9] Participants in other benefits plans will make the same assumption or will be uncertain about the extent of their retiree welfare benefits unless the Court clarifies this matter.

II. WELL ESTABLISHED RULES OF CONSTRUCTION FOR NON-ERISA INSURANCE PLANS SHOULD BE APPLIED TO ERISA INSURANCE PLANS.

This Court has not previously provided any guidance to the lower courts about how ERISA plans should be interpreted. The Sixth Circuit's interpretation of the plan at issue in this case is inconsistent with that of other circuits which have applied general insurance law to the interpretation of ERISA insurance plans. This Court should grant certiorari to eliminate the inconsistency that the Sixth Circuit has created.

The Retirees strongly disagree with the Sixth Circuit's conclusion that Respondents had clearly and unambiguously reserved

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[9] Moreover, the Sixth Circuit's interpretation of ERISA is inconsistent with other federal law on retirement benefits. In a labor law case, this Court has refused to allow employers to alter retiree pension rights without the retiree's consent. *Allied Chem. and Alkali Workers, Local Union No. 1 v. Pittsburgh Plate Glass Co.*, 404 U.S. 157 (1971).

> Retired employees have no economic or bargaining power within this [collective bargaining] system. Their financial security derives from past economic power pragmatically and prudently exercised. *Once retirement benefits have been bargained for, earned and become payable, the employer may not recant on his contractual obligation to pay them.*

Pittsburgh Plate Glass Co. v. NLRB, 427 F.2d 936, 946-47 (6th Cir. 1970), *aff'd sub. nom., Allied Chem. and Alkali Workers, Local Union No. 1 v. Pittsburgh Plate Glass Co.*, 404 U.S. 157 (1971) (interpreting federal labor law; emphasis added).

the right to change or terminate the retiree medical insurance program for those persons who had already retired. The court of appeals was able to arrive at this conclusion after a lengthy, painstaking, and erroneous review of the plan provisions. The court of appeals explained away those provisions of plan documents providing lifetime medical care at no cost after retirement with the excuse that these provisions were merely a then-present explanation that had no lasting effect. That court cited no authority for such a strained construction of the plan. Such an interpretation of an ERISA insurance plan is erroneous. Rather, the court of appeals should have applied rules of interpretation which have been well established in the interpretation of insurance policies.

The ERISA plan in question is nothing more than an insurance policy. As such, it should be interpreted consistently with previous interpretations of insurance policies, even if those policies were not governed by ERISA. Justice Brennan, in a concurring opinion joined by three other members of the Court, observed that "ERISA was *not* so 'carefully integrated' and 'crafted' as to preclude further judicial delineation of appropriate rights and remedies; far from barring such a process, the statute explicitly directs that the courts shall undertake it." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 157 (1985) (Brennan, J., concurring). Justice Brennan further noted that:

> Where the courts are required ... to fashion a federal rule of decision, the source of that law must be federal and uniform. Yet, state law where compatible with national policy may be resorted to and adopted as a federal rule of decision .... Here, of course, there is little federal law to which the court may turn for guidance. State regulation of *insurance*, pensions, and other such programs, however, provides a pre-existing source of experience and experiment in an area in which there is, as yet, only federal inexperience.

d. at 157, n. 18 (quoting *Wayne Chem., Inc. v. Columbus gency Service Corp.*, 426 F. Supp. 316, 325 (N.D. Ind.), *odified on other grounds*, 567 F.2d 692 (7th Cir. 1977) (emhasis added)).

In addition to the Seventh Circuit's reliance upon insurance w principles to interpret ERISA insurance plans, the Third ircuit has also approved of the reliance upon insurance law rinciples to interpret ERISA insurance plans. *Northeast epartment ILGWU Health and Welfare Fund v. Teamster ocal Union No. 229 Welfare Fund*, 764 F.2d 147, 159 (3d Cir. 985). Despite being expressly requested by the Retirees to app- insurance law principles to ERISA, however, the Sixth Circuit fused to do so. Moreover, the Sixth Circuit expressly disapoved of the Third Circuit's actual application of the insurance w principles applied in *ILGWU*.

The particular principle of insurance law the Sixth Circuit was ked to apply, but refused to apply, is the doctrine of asonable expectations. "The objectively reasonable expectaons of applicants and intended beneficiaries regarding terms of surance contracts will be honored even though painstaking udy of policy provisions would have negated those expectaons." Keeton, "Insurance Law Rights at Variance with Policy rovisions," 83 Harv. L. Rev. 961, 967 (1970). *See Van Orman American Ins. Co.*, 680 F.2d 301, 309-10 (3d Cir. 1982) (docine of reasonable expectations in ERISA case held to limit olicy provisions which, if read literally, would largely nullify insurance policy).

By rejecting this reasonable rule of construction that has been ell developed in insurance law, the Sixth Circuit turned the an in this case into a complete nullity. On the one hand the an promises certain benefits, but on the other hand the plan n be amended to avoid completely any obligation to provide e benefits. No rational person would fully pay for an inrance policy that could be completely terminated immediately

after payment with no refund of the premium. Yet, under the Sixth Circuit's holding, retired workers who spent a lifetime paying for retiree medical insurance have bought just such a nullity.

The Sixth Circuit's refusal to interpret an ERISA retiree insurance plan consistently with general rules of interpretation for insurance policies deviates from the position of other circuits that applied these principles. This Court should grant certiorari to bring consistency to the interpretation of ERISA welfare plans.

II. THE COURT SHOULD GRANT REVIEW TO DETERMINE THAT CONGRESS DID NOT ENACT ERISA IN ORDER TO GIVE EMPLOYERS A MEANS TO AVOID THEIR OBLIGATIONS TO RETIRED EMPLOYERS

The Sixth Circuit's reversal of the *Erie Lackawanna* decision provides a clear illustration of the need for Supreme Court review in this area. The Sixth Circuit has taken ERISA, a law designed to preserve and protect retiree benefits, and has used it to deprive retired workers of benefits to which they were entitled before ERISA.[10]

ERISA neither requires nor prohibits vesting of welfare plans. ERISA simply does not address vesting of welfare benefits except to exempt welfare plans from the accrual formula adopted for pension plans. *See* 29 U.S.C. § 1051(1). Because ERISA preempts state law, whether welfare benefits vest has become a question of federal common law. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987); *see Landro v. Glendenning Motorways, Inc.*, 625 F.2d 1344, 1351 (8th Cir. 1980) (Congress knew it had not answered all the ques-

[10] This alarming trend has been continued recently in the Second Circuit. *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488 (2d Cir. 1988). Immediate Supreme Court review is needed to return ERISA to its Congressional purpose of aiding, not injuring retirees.

tions that would arise under ERISA and intended federal courts to develop a body of federal common law to provide the missing answers).

Silence on whether welfare plans must vest is not disapproval of a promise that they will vest. The common law was clear; silence by Congress is more reasonably interpreted as approval of that common law. *See* Llewellyn, "Remarks on the Theory of Appellate Decision and the Rules or Canons About How Statutes Are to be Construed," 3 Vand. L. Rev. 395, 401 (1950).

Congress enacted ERISA to insure that retirees were not deprived of reasonably anticipated benefits. 29 U.S.C. § 1001(a). As such, ERISA is a remedial statute designed to protect beneficiaries of retirement plans and should be construed broadly to effect that purpose. *See Duchow v. New York State Teamsters Conference Pension and Retirement Fund*, 691 F.2d 74 (2nd Cir. 1982), *cert. denied*, 461 U.S. 918 (1983).[11]

In *Duchow*, the Second Circuit analyzed the effect of ERISA on pre-existing rights and stated:

> The compromise bill that became ERISA made it clear that Congress wished to preserve the already existing requirements as well.
>
> ... Certainly we have found no support for the proposition that Congress intended to eliminate what it perceived as a benefit already enjoyed by employees, and thereby to increase employees' losses of retirement plan benefits.

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[11] ERISA has also been interpreted as prohibiting unjust enrichment. *See, e.g., Airco Indus. Gases v. Teamsters Health & Welfare Pension Fund*, 618 F.Supp. 943, 950-57 (D. Del. 1985). The Sixth Circuit's decision in this case unjustly enriches Respondents by allowing them the benefit of many years of the Retirees' labor at a lower value than that promised. This inequitable result is inconsistent with Congressional intent.

91 F.2d at 78 (construing 29 U.S.C. § 1053(a)). No reason to nterpret ERISA in derogation of the common-law rights of the etirees exists.

By construing the absence of a vesting requirement and the resence of a procedural requirement for a written instrument s eliminating those common law rights, the Sixth Circuit made oo much of those provisions and too little of congressional in-nt.

CONCLUSION

It is abundantly clear that under pre-ERISA law and under xisting principles of insurance law, the Retirees would have ir-evocable contract rights to their promised medical insurance enefits. Congress never intended for ERISA to wipe out the etirees' reasonable expectation to these benefits. To the con-ary, the opposite is true. There is nothing in ERISA, its nderlying congressional intent, or any other social policy that ould suggest that an employer can break its promises of retire-ent benefits after it has used those promises to induce nployees to make their career with that employer. The Court ould grant review of this case to clarify the rights and obliga-ons of employers, employees, and retired employees with spect to retiree insurance benefits.

RESPECTFULLY SUBMITTED,

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APPENDIX

APPENDIX A

Nos. 85-5865/6092

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Robert L. Musto, et al.,
Plaintiffs-Appellees,

v.

American General Corporation, et al.,
Defendants-Appellants.

On appeal from the United States District Court
for the Middle District of Tennessee

Decided and Filed November 15, 1988

Before: NELSON and RYAN, Circuit Judges; and ENSLEN, District Judge.*

DAVID A. NELSON, Circuit Judge. In addition to providing a pension plan under which their retired employees are paid lifetime annuities, the National Life and Accident Insurance Company and its affiliates have, since 1939, maintained group insurance coverage for both active and retired employees. The coverage includes life insurance, accidental death and dismemberment insurance (for active employees only) and, since 1945, medical insurance.

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* Honorable Richard A. Enslen, United States District Judge for the Western District of Michigan, sitting by designation.

The group insurance has always been amendable at any time, and amendments have not been uncommon. Some of the amendments that were made over the years affected employees who had already retired, and others did not. Sometimes active employees were required to contribute part of the cost of one or more of the coverages they received, and sometimes they were not. In some years retirees who were younger than 65 had to pay part of the cost of their medical insurance, and in other years they did not. At no time between 1945 and 1984, however, was any retired National Life employee required to pay anything for medical insurance after age 65.

The cost of medical insurance was relatively low for several decades, and the level of insurance coverage historically provided by National Life was also low by today's standards. Not until 1971 was the dollar limit on the aggregate medical benefits payable over the entire course of an employee's retirement years raised from $5,000 to $10,000. Since that time, both costs and coverages have changed dramatically. The aggregate limit is now $200,000, for example, and in the first half of the current decade the cost of the medical insurance component of the group coverage increased by some 400 percent.

National Life and its parent holding company were acquired by defendant American General Corporation in 1982, and effective January 1, 1984, National Life employees were brought under a new medical insurance program comparable to American General's. That program, which was contributory as far as active employees were concerned, required all National Life employees who retired after January 1, 1984, to contribute approximately 20% to 25% of the cost of their medical insurance. Such retirees were given a choice of different coverages, for which different charges were imposed.

The new program was soon changed again; effective July 1, 1984, a revised medical insurance plan, applicable without regard to retirement date, eliminated the choice of coverages

and required all participating retirees who had reached age 65 to pay $16.10 per person per month. This was one-half the total cost of providing private medical insurance for people who, because they were 65 or older, qualified for the federal government's Medicare program. The plan provided that on July 1, 1985, the contribution level for early retirees (those under age 65) would increase from $14.87 per month (25% of total cost) to $29.75 (50% of total cost). The required contribution would drop back to $16.10 when the retiree reached the age of 65. The amendments also included an "escape clause" under which an early retiree who was eligible for medical coverage under another employer's plan would not be eligible under defendant's plan.

Contending, in essence, that each retired National Life employee had been given a vested contractual right to veto any change in his medical insurance, including any change respecting contributions toward the cost of the coverage, several retired employees brought a class action under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. Regardless of when they had retired, the plaintiffs sought to freeze their medical insurance coverage at the configuration that applied to them on June 30, 1984.

In addition to challenging the changes in their medical insurance, the plaintiffs sought to block an unrelated change involving pension benefits for spouses.

After conducting a four-day evidentiary hearing, the district court certified the case as a class action and issued a preliminary injunction which, among other things, restrained the defendants from implementing the July 1, 1985 medical insurance premium increase for retirees under age 65. See *Musto v. American General Insurance Corp.*, 615 F.Supp. 1483, 1494 (M.D. Tenn. 1985). The defendants sought guidance on how the order was to be carried out, and the district court thereafter issued a supplemental order amending the definition of the class

and giving instructions on implementation of the preliminary injunction. The defendants perfected separate appeals from the supplemental order and from the original injunction and class certification. The appeals have been consolidated.

The most significant of the several questions we are called upon to decide is whether the district court abused its discretion in issuing a preliminary injunction against implementation of the 1985 change in the medical insurance program.[1] Having concluded, for reasons explained below, that the plaintiffs failed to sustain their burden of showing the requisite likelihood of success on their claim that the changes in medical insurance coverage were impermissible, we shall reverse the order in which the injunction was granted.

I

Our starting point for determining the plaintiffs' rights under the group insurance policies is the actual language of the policies. ERISA requires that "[e]very employee benefit plan ... be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). A program under which an employer provides medical insurance benefits constitutes such a plan, see 29 U.S.C. §§ 1002(1)(A) and (3), and the insurance policy, in this case, is the "written instrument" required by law. (National Life's "Retirement Plan," under which the plaintiffs receive their pensions, is a separate plan, established and maintained pursuant to a separate written instrument; ERISA gives

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[1] Although implementation of the 1984 changes was not enjoined, the district court's opinion indicates that the court did not believe that any National Life employee who retired before 1984 could be required to make any contribution toward the cost of his medical insurance unless "the financial base of the entire corporation" were threatened. *Musto*, 615 F.Supp. at 1500. Defendants do not assert that such a threat exists.

employees "vested" (non-terminable) rights in the retirement plan, but not in the group insurance plan.[2])

The insurance policy that was in effect when most members of the plaintiff class retired is National Life and Accident Policy Number G7166, a "contributory" group insurance policy issued in 1966. The 1966 policy, which replaced one issued in 1955, remained in effect, subject to various amendments, until January 1, 1984.

The 1966 policy provided three different types of insurance coverage for active National Life employees: life, accidental death, and medical. Article 2 of the policy says that insurance of an employee under any of these three coverages "shall cease immediately" upon

> "(a) the date of the termination of employment of the Employee, except as provided in Section 5.07,
>
> (b) the date on which the Employee fails to make a required premium contribution for the coverage,
>
> (c) the date of termination of such coverage, or
>
> (d) the date of termination of this Policy."

Article 5 of the policy contains the medical insurance coverage. Section 5.07, captioned "Insurance After Retirement," says that "[a]fter the Retirement of an Employee in-

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[2] *Musto*, 615 F.Supp. at 1496 and 1497. A medical insurance plan comes within the statutory definition of a "welfare plan," 29 U.S.C. § 1002(1)(A), and does not come within the statutory definition of a "pension plan." 29 U.S.C. § 1002(2)(A). ERISA establishes minimum vesting standards for *pension* benefits, making some of such benefits non-terminable, 29 U.S.C. § 1053, but Congress declined to make *welfare* benefits non-terminable. *In re White Farm Equipment Co.*, 788 F.2d 1186, 1191 (6th Cir. 1986). The difference between retiree pension plan benefits and retiree welfare plan benefits is thus a "crucial" one. *Id.* at 1193.

sured hereunder, Group Comprehensive Medical Expense Insurance shall be continued on such Employee ... and, subject to the provisions set forth below, benefits shall be payable under the same conditions as those applicable in the case of an insured Employee."

Insured employees are required by Article 6 to make periodic contributions to the cost of all three of the coverages provided by the policy. Originally, retired employees who had not reached the age of 65 were required to make premium contributions for medical coverage just as active employees were. That requirement did not extend to retirees aged 65 or older. Under an amendment that became effective on April 1, 1973, the contribution requirement for medical insurance was ended—temporarily, as it turned out—with respect to all employees, active or retired. A few months later a contribution requirement was reintroduced for medical coverage on the dependents of new employees. These policy amendments, like all other policy amendments, were made known to the members of the group by duly published announcements.

Article 7 of the group insurance policy contains several "**General Provisions,**" one of which (§ 7.02) obligates the company to "issue for delivery to each insured Employee an individual certificate setting forth the benefits to which such Employee is entitled under this Policy. . . ." These certificates, § 7.02 says, "shall not constitute a part of this Policy."

Section 7.08 of the General Provisions, captioned "**Modification or Discontinuance of Policy,**" contains the following important language:

> "This Policy, or any insurance coverage hereunder, may be amended or discontinued at any time by an announcement duly published by the Company. The Company reserves the right to determine new premium contributions from time to time and at any time. Termination of this Policy, or any insurance coverage hereunder, or any

amendments hereto shall not require the consent of any Employee or beneficiary, nor shall such action require individual notice to any such person. Only the President, a Vice-President, the Secretary or an Assistant Secretary has power on behalf of the Company to make or modify this contract of insurance."

Section 7.11, captioned "**Entire Contract,**" says that "[t]his Policy and the individual applications of the Employees insured hereunder shall constitute the entire contract."

Nowhere in the entire contract is there any prohibition against amendments requiring premium contributions from retirees for whom no contribution requirement was in effect at the time of retirement, or from retirees whose contribution requirement ended upon their reaching age 65. What the policy says, rather, as we have seen, is that "[t]he company reserves the right to determine new premium contributions from time to time and at any time." If there is any ambiguity in this sentence, we have not been able to detect it.

The plaintiffs suggest that there is a negative pregnant in the next sentence of § 7.08, which declares that amendments to the policy "shall not require the consent of any Employee or beneficiary . . . ." Because the words "Retired Employee" are not used, plaintiffs argue, there is an implication that the consent of retired employees is required for amendments that affect them. This implication is strengthened, according to plaintiffs, by the fact that § 2.06 provides for termination of coverage when an "Employee" fails to make a required premium contribution, but not when a "Retired Employee" fails to make a required premium contribution.

We are not persuaded. The very section that provides for continuation of medical coverage for an employee after he or she has become a retired employee says that the coverage "shall be continued on such Employee;" the term used is "Employee," not "Retired Employee." Section 5.07 makes

post-retirement benefits payable, moreover, "*under the same conditions as those applicable in the case of an insured Employee.*" (Emphasis supplied.) If an active employee fails to make a required premium contribution, his coverage ceases automatically, under § 2.06, and no benefits are payable. If a 62 year-old retiree fails to make a required premium contribution, therefore, under the original policy, no benefits are payable to him either—and the fact that the term "Retired Employee" is not used in § 2.06 makes absolutely no difference. To interpret § 7.08 of the policy as implying that a retired employee must give his consent before the company exercises its reserved right to determine new premium contributions as to that employee would be unwarranted, in our view.

A new group medical insurance policy replaced the medical coverage of the 1966 policy effective January 1, 1984. The replacement policy is equally unambiguous as far as the company's right to amend is concerned. Here is what the general provisions of that policy say:

> "This policy may be amended or changed at any time, subject to the laws of the jurisdiction in which it is delivered, by written agreement between the Policyholder and the Insurance Company, without the consent of the persons insured hereunder or of their beneficiaries, if any."

The "Insurance Company" referred to in this provision is, by policy definition, The National Life and Accident Insurance Company (now, by change of name, American General Life and Accident Insurance Company). The "Policyholder" referred to is the same company, together with any subsidiaries and affiliates named in the policy. It is thus clear, as far as the 1984 policy language is concerned, that if the company decides to amend or change the policy, it may do so "at any time," subject to the laws of Tennessee, "without the consent of the persons insured . . . ."

II

Group insurance policies are not normally distributed to individual members of the group, but ERISA gives any beneficiary a statutory right to obtain a copy upon request—and the statute authorizes the imposition of substantial penalties for failure to comply with such a request in timely fashion. 29 U.S.C. §§ 1024(b)(4) and 1132(c). National Life employees were told in booklets distributed in accordance with the requirements of ERISA that they could examine the official plan documents during normal working hours and could obtain copies upon request.

Moreover, each insured employee of National Life automatically received an "individual certificate of insurance" in accordance with § 7.02 of the policy. The form of individual certificate of insurance applicable to active employees certifies that the employee is insured for designated coverages "in accordance with and subject to the conditions, definitions and provisions of Group Policy Number G7166." Page one of the individual certificate goes on to state, under the catchline "**Termination of Insurance,**" that insurance of an employee under any of the coverages provided by the group policy ceases automatically on termination of employment, with certain exceptions, or on "the date on which the employee fails to make a required premium contribution for the coverage; (c) the date the coverage is terminated by the Company; or (d) the date of termination of the Group Policy." The portion of the certificate dealing specifically with medical insurance says that medical insurance benefits similar to those described in the certificate are provided "on a limited basis" to retired employees who had medical coverage prior to their retirement. Nothing in the certificate suggests in any way that the company will be foreclosed from ever imposing new charges or from increasing charges already imposed for the medical coverage provided to retired employees.

The form of individual certificate issued to an employee upon is retirement likewise certifies that the retired employee is in-ured for designated coverages "in accordance with and subject o the conditions, definitions, and provisions of Group Policy Number G7166." Under the catchline "**Termination or Modification of Insurance,**" the retiree's individual certificate xpressly provides as follows:

> "The Group Policy, or any insurance coverage thereunder, *may be amended or discontinued at any time, and the Company reserves the right to determine new premium contributions at any time. Insurance under a coverage provided by the Group Policy ceases automatically* on the earliest of the following dates: (a) the date of death of the Retired Employee . . . (b) *the date the coverage or the Group Policy is terminated by the Company; or (c) with respect to Comprehensive Medical Expense Insurance* provided by the Group Policy, the date on which the last Aggregate Benefit limit shall have accrued or *the date on which a required premium contribution is not made.*" (Emphasis supplied.)

The certificates of insurance were not the only documents istributed to members of the plaintiff class. From 1969 to 982, National Life sent each employee an annual "Benefacts eport," or "personal statement of benefits." Each such eport noted that it "was prepared by Benefacts, Inc., a con-ulting firm specializing in the preparation of personalized eports on company benefit programs." Subject to the caveat iat "the amount and availability of benefits are controlled by ie terms and conditions of each plan," each Benefacts Report resented a skeletal summary of the employee's current medical surance benefits, disability insurance benefits, and life in-rance benefits. The report also gave a dollar figure for the nployee's estimated monthly pension upon retirement at age 5, and noted that medical and life insurance benefits would ontinue after retirement subject to certain reductions in

nt. The brief discussion of post-retirement benefits con-
d with a statement—perfectly accurate at the time—to the
: that "[y]ou are not required to contribute for these
its after your retirement." The Benefacts Report said
ng one way or the other about the possibility of future
dments regarding insurance benefits.

at possibility was specifically and clearly addressed in a
: of employee booklets intended, as some of the early
lets put it, to explain the company's benefit program "in
understood terms." The first such booklet provided us
respect to the 1966 group insurance policy came out in
That booklet, prepared for distribution to all employees,
on its first page that "[c]omplete provisions and conditions
ontained in the master group policy, which is the final
rity in all situations." Under the caption "**Continuation**
e Program," the last page of the booklet says this:

"The Group Insurance provisions of the Security Program
have been arrived at after careful study, and it is the Com-
pany's expectation that they will be continued indefinitely.
However, since it is not possible to foresee the future, the
Company must reserve the right to change or even discon-
tinue these provisions if it becomes necessary."

to post-retirement medical insurance coverage, the 1968
let summarizes the provisions of the policy as follows:

"After your retirement, Comprehensive Medical Ex-
pense Insurance coverage will continue on you, and on
your spouse if your spouse has been continuously covered
during the five-year period immediately preceding your
retirement. There will, however, be new limitations on the
total amount of benefits that will be paid.

If you are 65 years of age when you retire, the total
amount of benefits for your covered expenses thereafter
may not exceed $5,000.

* * * * * *

Contributions for yourself and your spouse, separately computed, are required to your respective 65th birthdays, at which time contributions cease. Benefits limits applicable after your retirement cannot be reinstated."

This is an accurate summary of policy provisions in effect at the time the booklet was issued.

By 1977 ERISA had made it mandatory for the administrator of a welfare plan such as National Life's to furnish each participant a "summary" description of the plan, "written in a manner calculated to be understood by the average plan participant ..." 29 U.S.C. §§ 1022(a)(1) and 1024(b)(1). National Life's statutory "summary plan description" for 1977—a summary set forth in a booklet similar to those the company had been distributing voluntarily for some years — appears to meet the statutory requirements.

Under the catchline "**Plan Documents,**" the 1977 summary says this:

"This description of the Plan summarizes the official Plan Documents. We have tried to write this summary in clear[,] understandable and informal language. However, you should refer to the official Plan Documents for more extensive information about your benefits. In the event of any conflict between the information in this summary and the official Plan Documents, the official Plan Documents will govern.

You are entitled to examine the official Plan Documents *** during normal working hours at the Security Program Division of the Plan Administrator. If you would rather have a copy of these documents, send a written request to the Plan Administrator. There will be a charge to cover copying costs."

Immediately preceding this language in the 1977 booklet is a paragraph captioned "**Continuance of Plan.**" It reads as follows:

"The Company fully intends to continue the Plan in-
efinitely and to meet any foreseeable situations that may
ccur. However, the Company does, as it always has,
eserve the right to change the Plan and, if necessary,
iscontinue it."

1977 booklet's summary of the post-retirement medical
nce provisions then in effect is similar in format to that
ned in the 1968 booklet, but it reflects several intervening
es in the terms of the policy. By 1977,

- coverage for a spouse was no longer conditioned on the spouse having been continuously covered for the five years preceding retirement;
- the aggregate limit on a retiree's post-retirement benefits was not $5,000, but $100,000; and
- contributions were no longer required from retirees under the age of 65; regardless of age, as the summary stated, "[n]o contributions are required for continued coverage on you and your spouse after retirement."

977 booklet appears to provide an accurate summary of
licy provisions then in effect.

final summary we have been furnished is the 1981 sum-
lan description of the group medical insurance plan for
employees. Under the catchline "**Contributions to the**
' the 1981 summary says "[t]he Company pays the entire
f the Plan with respect to Retired Employees." On the
page, under the catchline "**Continuance of Plan,**" the
ummary reiterates, in language unchanged since 1977,

"[t]he Company fully intends to continue the Plan in-
efinitely and to meet any foreseeable situations that may
ccur. However, the Company does, as it always has,

reserve the right to change the Plan and, if necessary, discontinue it."

III

Because the summary plan description booklets were distributed to everyone, while the actual policy was not, a person who had not spent years in the insurance business, or who failed to read the booklets carefully, might have assumed that the legal obligations incurred by National Life under the insurance policy were defined not by the language of the policy itself, but by the booklets in which the policy was summarized. Such an assumption would conflict with what is said in the booklets ("the official Plan Documents will govern"), it would conflict with what is said in the policy ("[t]his Policy . . . shall constitute the entire contract"), and it would seem to conflict with what is said in ERISA (the plan must be established pursuant to "a written instrument," of which the participants are to be furnished a "summary").[3]

The district court itself may have come close to thinking that the *fons et origo* of the company's obligations under its group insurance plan lay in the summaries, and not in the instrument being summarized. Acknowledging that "a right to change or terminate medical and life insurance appeared in the official master plan documents or policies," the court dismissed the "official" documents in a single sentence: "These documents, however, were not distributed to employees, nor were they

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[3] *Cf. Bryant v. International Fruit Products Co.*, 793 F.2d 118, 123 (6th Cir.) ("the handbook is not a part of the plan agreement and cannot be relied upon to modify or affect any provisions of the plan...."), *cert. denied*, 479 U.S. 986, 107 S.Ct. 576, 93 L.Ed.2d 579 (1986). But see *Edwards v. State Farm Mutual Automobile Ins. Co.*, 851 F.2d 134 (6th Cir. 1988), holding that the trustees of a pension plan acted arbitrarily and capriciously in denying disability benefits to an employee who was eligible for such benefits under the language of a summary plan description, but not under the language of the plan itself.

readily available."[4] 615 F.Supp. at 1488. The court then turned to the summary plan descriptions, and found their provisions to be in irreconcilable conflict:

> "The termination/modification clause contained in the [National Life] summary plan descriptions clearly and expressly reserve[s] the right to amend and terminate the medical insurance benefit plan. At the same time, however, the plan descriptions also promise to continue the plans after the plaintiffs' [sic] retired, without further cost to the retiree. The Court cannot read both provisions together without reaching the conclusion that the provisions conflict and require interpretation of what the parties mutually intended by placing the terms in the agreement. As stated in [*International Union v. Yard-Man Inc.*, 716 F.2d 1476 (6th Cir. 1983), *cert. denied*, 465 U.S. 1007, 104 S.Ct. 1002, 79 L.Ed.2d 234 (1984)], the agreement's terms must be construed to avoid nugatory and illusory promises. To read the plan as providing lifetime paid up medical insurance and, at the same time, reserving the right to terminate the benefits at any time constitutes an illusory promise—an express unqualified grant of a right negated by an express unqualified reservation of the right to terminate the grant." 615 F.Supp. at 1499.

Regardless of how much weight should be given to the language of the plan summaries, as opposed to the language of the insurance policies themselves, it seems to us that the district court erred, as a matter of law, in determining that the provisions of the plan summaries cannot be reconciled with one

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[4] It is true that the complete policies were not distributed to employees who did not request them; under ERISA, there was no requirement that the master plan documents or policies be distributed to employees who had not asked for them. If the policies were not "readily available," however, National Life was violating ERISA. The court cited no facts that would support such a conclusion.

another. Our understanding of what the summary plan descriptions say is this:

1. Here is a plain-English summary of the group insurance plan for employees of National Life.

2. The plan provides medical insurance coverage for eligible employees.

3. The plan provides for continuation of medical coverage after retirement.

4. The plan does not require contributions for continued medical coverage after retirement.

5. The company reserves the right to change the plan.[5]

To read this summary as saying that the plan can never be changed in such a way as to to (sic) mandate retiree contributions for continued medical coverage is to read into the summary something its authors did not put there (a promise to provide lifetime "paid up" medical insurance), while reading out of the summary something that clearly was put there (an express reservation of the right to change the plan). Such a reading violates the basic principle that each provision of a contract should be interpreted as part of an integrated whole, to the end

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[5] The 1968 booklet might conceivably be read as saying that the company reserves the right to change the plan "if it becomes necessary," while subsequent versions of the booklet contained no such qualification on the right to change the plan. This minor change in wording has little or no significance, in our view; it antedated major policy changes of which the plaintiffs want to take advantage, it brought the booklets into better alignment with the actual language of the policy, and it did not materially affect the company's expressly reserved right to amend the policy. The 1968 version of the booklet cannot fairly be read as saying that the company reserves the right to change or even discontinue the policy only if it becomes necessary to do so in order to avoid bankruptcy or some comparable threat to the financial base of the entire corporation.

that *all* of the provisions may be given effect if possible. See *Yard-Man*, 716 F.2d at 1479.

Wherein lies the supposed conflict in the summary plan description booklets?

— Each booklet, as far as we can see, did accurately summarize the main features of the group insurance policy as in effect at the time the booklet was issued;

— The group insurance policy did, at all times, provide medical coverage for eligible employees;

— The policy did, at all times, provide for continuation of medical coverage after retirement;

— Medical coverage was in fact continued for each retiree, regardless of insurability, as long as the retiree complied with the conditions of the policy;

— When the policy called for contributions from certain retirees, as it did in the 1960s, the booklets said so. When the policy did not call for contributions from any retiree, the booklets said that too. No booklet ever said that the policy would not be changed in the future to require contributions for continued coverage,

— and when the company made such a change in 1984, it was doing something that the booklets had said all along it had the right to do.

IV

Although the contract of insurance clearly permitted amendments, and although welfare plans, as distinguished from pension plans, are not subject to the "vesting" provisions of ERISA, it remains to be considered whether National Life's retirees were the beneficiaries of separate unilateral contracts

under which National Life was estopped from exercising its right to amend the insurance coverage. The plaintiffs argue forcefully that each National Life employee did become the beneficiary of such a unilateral contract upon retirement. The district court, expressing agreement with the analysis found in "a case remarkably close on point," *In re White Farm Equipment Co.*, 42 B.R. 1005 (N.D. Ohio 1984), accepted the plaintiffs' argument. *Musto*, 615 F.Supp. at 1498. The *White Farm* judgment was subsequently reversed by this court, however, in a decision reported at 788 F.2d 1186 (6th Cir. 1986), and under our holding in *White Farm*, it appears most unlikely that the plaintiffs in the case at bar will ultimately prevail on their principal claim.

The central issue raised in the *White Farm* appeal was "whether under ERISA an employer may lawfully exercise a reserved power to terminate an employee welfare benefit plan for retired nonunion employees." 788 F.2d at 1190. After distinguishing the pre-ERISA case of *In re Erie Lackawanna Railway Co.*, 548 F.2d 621 (6th Cir. 1977), and noting that after ERISA "we are not bound to follow the Ohio law construed there," we concluded that where the power to terminate such a welfare plan has been reserved, it may be exercised: "the parties may themselves set out by agreement or by private design, as set out in plan documents, whether retiree welfare benefits vest, or whether they may be terminated." 788 F.2d at 1192 and 1193. We went on to hold that "the district court erred in ruling that an employer may not terminate, as a matter of 'federal common law' under ERISA, the welfare benefits of its retired employees," and we remanded the case for consideration of the question whether an agreement or "private design" set out in the governing plan document provided for the vesting of welfare benefits on retirement, or provided that such benefits could be terminated. 788 F.2d at 1193-94. (The governing plan document was not available in *White Farm*, and its terms could only be shown through indirect evidence.)

Although the "plan document" required by 29 U.S.C. § 1102(1) was not before us in *White Farm,* such a document is before us in the case at bar. As we have seen, the document is unambiguous; instead of providing that the company may never require a premium contribution for medical coverage after retirement, the plan document provides just the opposite. As far as the plan itself is concerned, it is perfectly clear that no immutable insurance benefits can be said to vest upon retirement.

Whether, under ERISA, employees can ever obtain vested rights in welfare plan benefits on the strength of written representations outside the official plan document is a question we need not decide—for none of the "unofficial" documents called to our attention promised that all of an employee's medical insurance premiums would be fully and permanently "paid up" upon retirement, regardless of how the medical insurance policy might be amended thereafter. If any document furnished to any employee or any prospective employee represented that medical insurance benefits would be "irrevocable or permanently fully 'paid up' by the employer" after retirement (see *Musto,* 615 F.Supp. at 1486), that document has not been included in the record of this case.

It is true that National Life promoted its employee benefit package—which included a retirement plan component—as an inducement for people to come to work for the company and to remain in its employ. A recruiting brochure received in evidence as Exhibit 21, for example, told the prospective employee employee that he or she would have group life insurance "[f]rom the very first day at work;" that "[y]ou and your eligible dependents are all covered under an excellent comprehensive medical expense insurance plan" for which "[t]here is no cost to the employee unless you elect coverage on your dependents;" and that "[i]f you're disabled and can't work, your income continues" under disability coverage. The brochure then turns to the subject of retirement—and the discussion of that subject is confined entirely to a description of the *pension* benefits

available under the company's *retirement plan*. The description of the retirement plan—a description that concludes with the words "The Company pays all the cost[;it's] National Life's way of saying 'thank you' for years of loyal service, and we think it's a good way"—says nothing whatever about post-retirement medical insurance or life insurance coverage. No insurance benefits were provided under the retirement plan, of course, and the recruiting brochure does not even tell the prospective employee that under the welfare plan medical coverage will be continued after retirement, much less promise that post-retirement medical coverage will be "irrevocable" or "permanently fully 'paid up.' " And under ERISA, as we have seen, the fact that an employee acquires a vested, non-terminable right to *pension* benefits such as those described in Exhibit 21 does not in any way suggest that the employee acquires a comparable vested right to medical insurance benefits under a *welfare* plan that does not provide for the vesting of such benefits.

Once an individual was hired by National Life, he or she received copies of a magazine put out by the company for its employees. Plaintiffs invite our attention to one issue of that magazine, different editions of which were received in evidence as Exhibits 8 and 9; this issue was devoted to a review of the employee benefit package as it stood in the summer of 1970. The magazine gave a lengthy description of the National Life "Retirement Plan"—the *pension* plan, which the magazine called "[t]he backbone of your total Security Program"—and the magazine reported that employee contributions were no longer required for this retirement program:

> "Of particular note is the fact that, beginning January 1, 1969, no contributions are made to the retirement program by employees. The entire cost of the Retirement Plan is paid by National Life."

As far as medical insurance coverage was concerned, in contrast, the magazine made it clear that contributions were still required from one class of retiree:

"After your retirement, comprehensive medical expense insurance coverage will continue on you and on your covered spouse. There are, however, limitations on the total amount of benefits that will be paid.

If you retire at age 65, the total amount of benefits for your covered expenses thereafter may not exceed $5,000.

* * * * * *

Contributions for yourself and for your spouse are required to your 65th birthdays, at which time contributions cease."

owhere in that or any other employee publication—or in any emorandum, letter, brochure, report, or other written document, as far as we have been able to ascertain after a careful arch of the record—did the company ever promise any nployee that all premiums for post-retirement medical verage would be irrevocably "paid up" upon the employee's irement.[6]

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[6] The employer may have gone farther in this direction in *Moore v. etropolitan Life Insurance Co.*, 856 F.2d 488 (2d Cir. 1988), where rious employee newspaper articles, letters, memoranda, and film ips described the company's welfare plans as providing "lifetime" nefits "at no cost." Notwithstanding these written presentaons—which did not generally refer to the company's right to amend terminate benefits—the court held that there was no unilateral ontract" for lifetime benefits at no cost.

Like the record in the case at bar, the record in *Moore* contained o hint of bad faith, intent to deceive or even conduct that was obtively, if unintentionally, misleading. . . ." *Id.* at 492. Affirming a ant of summary judgment for the employer, the court of appeals clared in *Moore* that "the unambiguous provisions of the plan must vern, because altering a welfare benefit plan on the basis of nonan documents and communications, absent a particularized showing conduct tantamount to fraud, would undermine ERISA." *Id.* at 9.

What employees may have been told orally is harder to reconstruct, of course, but the memories of the witnesses should have been relatively fresh as to more recent oral communications. In October and November of 1983, a series of employee meetings was held across the country to tell National Life Employees about the prospective integration of their welfare and pension plans with the American General plans. We are given to understand that the majority of the more than 2,000 people in the plaintiff class had already retired by the fall of 1983, and they were not asked to attend the meetings.[7] Active employees who attended the meetings were given a description of the American General benefit programs and were told that they would come under those programs—which were contributory—if they remained in active service past January 1, 1984.

As far as their *pension* rights were concerned, the National Life employees were told that they would automatically become members of the American General Retirement Plan on January 1. To assure that no vested pension benefits would be lost,

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[7] National Life employees who had already retired were brought up to date by a letter that the President of National Life sent the company's retirees under date of November 18, 1983. The letter explained that American General's benefit programs were going to be adopted for active National Life employees effective January 1, 1984, but that there would be no change in the group life insurance coverage or pension plan benefits for National Life people who had already retired. As far as medical insurance coverage was concerned, the retirees were told that changes were in the offing and that contributions from all National Life retirees might be required beginning July 1, 1984:

> "[B]ecause of the continuing increase in health care costs, it will be necessary to modify your medical insurance, effective July 1, 1984. At that time there will be changes in the form of your medical coverage and *some level of contribution may be required*. The new plan form and contribution level will be consistent with those for all American General retirees." (Emphasis supplied.)

wever, benefits at retirement would be calculated two ways: ıder the National Life pension plan's formula, and under the merican General pension plan's formula. The retiring nployee would receive the larger of the two amounts, thus get- ıg "the best of both worlds."

As far as *medical insurance* coverage was concerned, the Na- ɔnal Life employees were told that on January 1, 1984, they ould have coverage under the American General medical plan their choice if they completed the appropriate enrollment rms and paid the required contribution. Anyone retiring efore January 1 would continue to have coverage under the ex- tin̲g National Life medical scheme. The people conducting the eetings apparently did not volunteer, as one would certainly ave expected them to do, that coverage changes were in the of- ng, or that contributions might be required starting July 1; but e district court found that if asked a specific question about e possibility of termination (or, presumably, modification), e people running the meetings did mention the termination ause. *Musto,* 615 F.Supp. at 1490. (As it turned out, a person ho retired prior to January 1 to save medical insurance costs ould at least have been no worse off in that regard than if he ad retired six months later; the early retiree had to make no ntributions until July 1, 1984, and after that date the same ntributions were required from all retirees of the same age, gardless of retirement date.)

Nowhere in the district court's opinion is there a specific find- g that any National Life employee received an oral promise at his post-retirement medical insurance coverage would be rmanently, irrevocably, and fully "paid up." We cannot be

certain that no such oral promise was ever made;[8] but we are quite certain that Congress, in passing ERISA, did not intend that participants in employee benefit plans should be left to the uncertainties of oral communications in finding out precisely what rights they were given under their plan. That is why ERISA makes it mandatory that "every" plan be established and maintained under "a written instrument." 29 U.S.C. § 1102(a)(1).

The legislative history of § 1102(a)(1) explains that "[a] written plan is to be required in order that every employee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan." H.R. Rep. No. 1280, 93d Cong., 2nd Sess. 4639 at [1974] U.S. Code Cong. & Admin. News 5077. Other courts that have considered this Congressional policy have concluded that the clear terms of a written employee benefit plan may not be modified or superseded by oral undertakings on the part of the employer. See, *e.g.*, *Nachwalter v. Christie,* 805 F.2d 956 (11th Cir. 1986) (written employee benefit plans governed by ERISA may not be modified by oral agreements); *Saret v. Triform Corporation,* 662 F.Supp. 312 (N.D. Ill. 1986) (oral representations that

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[8] Mr. Robert Musto, the lead plaintiff, testified that at no time during his 29 years as an active National Life employee did anyone ever tell him that the company would not make changes in retirement and medical benefits. Mr. Musto, who retired as an assistant secretary of National Life in January of 1983, also testified that he himself never told anyone the company would not change medical benefits after retirement. But Mr. Thomas Gater, a retired National Life agent, testified that in 1975 he asked his district manager — did he think it would ever change, our benefits after retirement and he said never." And Mr. L. G. Laurence, a retired National Life vice president, testified that at district managers' meetings "I would hit the fact that they were going to have paid-up medical insurance, hospitalization insurance at no cost to them or their wives after retirement." Mr. Laurence conceded, on cross examination, that he could not recall telling anyone that the company would never make a change in benefits after the person retired.

.iff was covered under a benefits plan did not estop com- when written plan limited participation to full time ɔyees and plaintiff was not a full time employee); *Audio ity v. Pension Benefit Guaranty Corporation,* 624 F.2d 513 Cir. 1980) (oral testimony inadmissible to vary the unam- ɔus written terms of an ERISA pension plan); *see also son v. Central States, Southeast and Southwest Areas Pen- Funds,* 513 F.2d 1173, 1174-75 (10th Cir. 1975) (benefits not be enforced according to informal agreements in a let and a letter that are inconsistent with the terms of a en pension plan); *San Pedro Fishermen's Welfare Trust Local 33 v. DiBernardo,* 664 F.2d 1344 (9th Cir. 1982) modifications of a written trust fund agreement will not be gnized under § 302(c) of the Labor Management Relations We agree with the conclusion reached in those decisions.

s not always easy to determine exactly what a benefit plan even when the language of the plan has been reduced to g. If the terms of these often complex plans could be to depend upon evidence as to oral statements that may ave been worded very precisely in the first place, that may been made many years earlier, and that cannot be proved t through the testimony of lay witnesses whose memories eldom be infallible and who, being human, may have tend- hear what they wanted to hear, the degree of certainty that ress sought to provide for would be utterly impossible to .

V

e defendant in this case, as the district court indicated, three different roles simultaneously. In its corporate role ployer, first of all, the company must see that such benefit as it chooses to maintain are designed to further the com- s business interests in consonance with the company's tions to its stockholders. (Among the most significant nolders in many large corporations today, of course, are

trustees of pension plans or other employee benefit plans maintained for people who seldom have any idea of the extent to which they are the true owners of the nation's business enterprises.) In its role as plan administrator, secondly, the company must exercise fiduciary responsibilities in managing and controlling any assets of the plan (except insofar as such assets consist of insurance policies or insurance company assets, see 29 U.S.C. § 1103(a) and (b)). And the company must discharge its administrative duties solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits and defraying reasonable expenses of administration. 29 U.S.C. § 1104(a)(1). In its role as insurance carrier, finally, the company must properly discharge all obligations assumed by it under the terms of the insurance policy, and must comply with a whole panoply of requirements imposed under various state insurance laws.

With respect to the second of these three roles—that of administrator—the district court seems to have believed that there was a breach of fiduciary responsibility: "The unilateral amendments to the retiree's benefits ... reflect overreaching." 615 F.Supp. at 1497 n. 10. The court expressed the view that as administrator of the welfare plan, the company held the insurance policies in a fiduciary capacity and was required to administer the policies "solely in the interests of the retirees." *Id.* at 1502. The court found, moreover, that "the plaintiffs have a substantial likelihood of success on the proposition that [the defendant] was subject to a fiduciary duty with respect to holding and protecting the issued insurance policy covering the medical insurance plan." *Id.* at 1502-03.

If we ignore the problem posed by the fact that "any assets of a plan which consist of insurance contracts or policies" are expressly exempted from the statutory requirement that "all assets of an employee benefit plan shall be held in trust," 29 U.S.C. § 1103(a) and (b), we agree with the district court that the company, in its capacity as administrator of the welfare plan, had a

ɔ "take and keep exclusive control of the [insurance] con-
and ... to use prudent care and skill to preserve this pro-
" H.R. Conf. Rep. No. 93-1280, 93rd Cong. 2d Sess.,
ted in [1974] U.S. Code Cong. & Admin. News, 5038,
Whatever statutory housekeeping responsibilities the
any may have had with regard to the insurance policies,
ɔver, the company clearly had a duty to pay insurance
its to those who qualified for such benefits under the
es' terms. But if the district court intended to suggest that
istence of such obligations could somehow prevent the
any, in its role as employer, from making any change in
sign of its welfare plans other than a change for the "ex-
e purpose" of benefiting the plans' participants and their
ciaries, we believe that the court's understanding of the
e was very seriously flawed.[9]

ere is a world of difference between administering a
e plan in accordance with its terms and deciding what
terms are to be. A company acts as a fiduciary in perfor-
the first task, but not the second. As this court, speaking
gh Judge Celebrezze, declared in *Moore v. Reynolds*
s Co. Retirement Program*, 740 F.2d 454, 456 (6th Cir.

'[n]either Congress nor the courts are involved in either
he decision to establish a plan or in the decision concern-

. Donald S. Grubbs, Jr., a consulting actuary and attorney who
etained to advise the Senate subcommittee that developed
, testified as an expert witness that Congress clearly did not
ɲpt to preclude the right of employers to reduce benefits" under
e plans. In response to a suggestion from the district court, Mr.
s testified that nothing in ERISA requires that an employer
as a condition to making a modification in a welfare plan
e to the interests of the plan participants, "that the plan is going
belly up if they don't make this modification." The court
ed from the bench that "I don't put any credence at all in this
ɔny," but we read the statute just as Mr. Grubbs did.

> ing which benefits a plan should provide. In particular, courts have no authority to decide which benefits employers must confer upon their employees; these are decisions which are more appropriately influenced by forces in the marketplace and, when appropriate, by federal legislation."

Congress, as the Court of Appeals for the Fourth Circuit pointed out in *Sutton v. Weirton Steel Div.*, 724 F.2d 406, 411 (4th Cir. 1983), *cert. denied,* 467 U.S. 1205, 104 S.Ct. 2387, 81 L.Ed.2d 345 (1984), "has not prohibited an employer who is also a fiduciary from exercising the right accorded other employers" to amend plan provisions regarding unfunded contingent benefits. Such changes, the court declared, "are not to be reviewed by fiduciary standards." *Id. Cf. Amato v. Western Union International, Inc.*, 596 F.Supp. 963, 968 (S.D.N.Y. 1984) (employer that is also plan administrator "wears two hats," and is only to be judged as a fiduciary when functioning as a plan administrator), *modified,* 773 F.2d 1402, 1416-17 (2d Cir. 1985), *cert. dismissed,* 474 U.S. 1113, 106 S.Ct. 1167, 89 L.Ed.2d 288 (1986).

Moore and *Sutton* both happen to have involved pension plans, but the principle articulated in those cases applies with at least as much force to welfare plans such as those at issue here. See *Viggiano v. Shenango China Division of Anchor Hocking,* 750 F.2d 276 (3d Cir. 1984) (hospitalization plan case citing retirement plan cases). National Life had no fiduciary duty to establish any medical insurance plan, much less one that could never be amended without the approval of those to whom it applied. It is hard to see how the company's express reservation of a right to amend the plan can be said to constitute "overreaching" when a prudent employer, mindful of the possibility that medical costs might skyrocket, could well have decided, if given the slightest reason to suppose that future amendments to the medical insurance coverage could be invalidated under ERISA, not to provide such coverage at all, or to impose the most stringent limits on any coverage provided.

The case law, in any event, makes it clear that when an employer decides to establish, amend, or terminate a benefits plan, as opposed to managing any assets of the plan and administering the plan in accordance with its terms, its actions are not to be judged by fiduciary standards. "ERISA's concern is with the elements of a plan and its administration after it has been established rather than to mandate the creation of a program. ERISA does not require an employer to establish a hospitalization plan nor continue it indefinitely." *Viggiano,* 750 F.2d at 279. *See also Amato v. Western Union International, Inc.,* 773 F.2d 1402, 1417 (2d Cir. 1985) (company officers "acted on behalf of a corporate employer and not as Plan fiduciaries in amending its pension plan"), *cert. dismissed,* 474 U.S. 1113, 106 S.Ct. 1167, 89 L.Ed.2d 288 (1986); *Cunha v. Ward Foods, Inc.,* 804 F.2d 1418, 1432-33 (9th Cir. 1986) (decision to terminate a pension plan was a business decision, not made by company in connection with its fiduciary responsibilities as plan administrator); *Chait v. Bernstein,* 645 F.Supp. 1092 (D.N.J. 1986) (decisions of defendant to amend and terminate a pension plan would not be governed by ERISA's fiduciary duties), *aff'd,* 835 F.2d 1017 (3d Cir. 1987).

The logic of the foregoing cases also disposes of plaintiff's contention that it constituted a breach of fiduciary responsibility for the company to adopt an "escape clause" terminating coverage on an early retiree who became eligible for medical coverage under another employer's group medical plan. If it would not have been illegal for the company to terminate medical coverage for everyone, whether covered elsewhere or not, we do not believe that it was illegal to terminate coverage only for early retirees who could get coverage through another employer.

Relying upon *Northeast Department ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund,* 764 F.2d 147 (3d Cir. 1985), which held that an escape clause in a *multi-employer* medical insurance plan was unenforceable

under ERISA's fiduciary standards, the district court declared that the clause at issue here is unenforceable as a matter of law. *Musto,* 615 F.Supp. at 1503-04. The court's reliance on *ILGWU* was, we believe, misplaced.

In amending a *multi-employer* plan, where the level of contributions of each participating employer has generally been set by collective bargaining, the trustees "affect the allocation of a finite plan asset pool between participants," as defendants point out in their brief, and hence act as plan administrators subject to a fiduciary duty. But when, as here, there is only one employer, there is normally no "plan asset pool" to be affected. In amending a single employer plan, therefore, the company normally acts in its role as employer, not in its role as fiduciary. To the extent that dicta in the *ILGWU* decision suggest that escape clauses in single employer plans are automatically invalid, we respectfully disagree.

As a practical matter, the issue may be unlikely to arise in the future. We are told that recent changes in many state insurance codes have made the new employer's medical coverage primary and the retiree coverage secondary, thus removing much of the impetus for adoption of escape clauses. (Subsequent to entry of the order appealed from in this case, indeed, as the defendants advise us, the American General welfare plan was amended to eliminate the escape clause of which plaintiffs had complained.)

VI

The final branch of the order that is under consideration here involves the National Life pension plan, as opposed to the medical insurance plan.

Prior to 1984, a married employee who took early retirement could obtain a pension equal in amount to the "single life" annuity that an unmarried employee would receive, but with the added attraction that if the married employee died before reaching the age of 65, his surviving spouse would receive an an-

nuity (reduced by 50%) for the rest of the spouse's life. If he lived to age 65, the retiree could elect to continue receiving annuity payments on a "single life" basis, in which event there would never be any benefits for the surviving spouse, or the retiree could accept a "joint and survivor" annuity, with benefits for the retiree being reduced in the amount necessary to pay for the survivor's benefits. Because the necessity of making an election was deferred until the retiree turned 65, the spouse had the potential for a free ride until that time. In May of 1984, however, the company announced a change, effective January 1, 1984, under which an election not to accept a joint and survivor annuity had to be exercised upon retirement, and could not be postponed until age 65. The possibility of a "free ride" for spouses thus came to an end.

"Unlike medical insurance benefits," as the district court pointed out, "spousal survivor benefits constitute a form of pension benefit and are therefore covered by the comprehensive vesting ... provisions under ERISA." *Musto,* 615 F.Supp. at 1504. It is clear, however, that prior to July 30, 1984 (the effective date of the Retirement Equity Act of 1984, P.L. 98-397) the vesting rules of ERISA did not apply to "any value in a plan's joint and survivor annuity provisions to the extent that exceeds the value of what the participant would be entitled to receive under a single life annuity." H.R. Rep. No. 807, 93rd Cong., 2d Sess. *reprinted* in [1974] U.S. Code Cong. & Admin. News 4670, 4726. It is undisputed that the "free ride" spousal survivor benefits at issue here did not constitute part of the value of what a participant would be entitled to receive under a single life annuity, and these spousal survivor benefits therefore did not vest by operation of statutory law. If the spousal survivor benefits were non-terminable, it can only have been because the plan document made them non-terminable.

But the district court did not find that the plan document made the early retiree spousal survivor feature

non-terminable.[10] What the court found, rather, was that the elimination of this feature "constitutes arbitrary and capricious conduct in violation of [defendant's] fiduciary duties." *Musto,* 615 F.Supp. at 1504. That finding, we believe, was clearly erroneous.

Amendments to single-employer pension plans, like amendments to single-employer welfare plans, are not made in the employer's role as fiduciary. *Amato,* 733 F.2d at 1417; *see also Ogden v. Michigan Bell Telephone Co.,* 657 F.Supp. 328 (E.D. Mich.), *appeal dismissed,* 829 F.2d 1126 (6th Cir. 1987). There was no fiduciary duty to be broken insofar as the spousal survivor amendment is concerned.

VII

Defendants ask us to invoke the pendent jurisdiction doctrine and vacate the certification of the plaintiff class. Plaintiffs maintain that we have no jurisdiction to decide the class certification issue on an interlocutory appeal such as this. *Alexander v. Aero Lodge No. 735, Int'l Ass'n of Machinists and Aerospace Workers,* 565 F.2d 1364, 1370 (6th Cir. 1977), *cert. denied,* 436 U.S. 946, 98 S.Ct. 2849, 56 L.Ed.2d 787 (1978), and *Curran v. Merrill Lynch, Pierce, Fenner and Smith,* 622 F.2d

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[10] The plan document contains an express reservation of "the right to amend the Plan at any time or from time to time," but also provides that "[n]o such action will operate ... adversely to affect the pensions of Members already retired ..." Plaintiffs argue that the amendment in question adversely affected the pensions of a few early retirees who had retired before the amendment was announced, while defendants argue that the no-cost survivor benefit was not part of the "Member's" pension. The district court not having resolved this question, we decline to express an opinion on it. For the same reason we decline to express ourselves on the question whether, notwithstanding the fact that 26 U.S.C. § 412(c)(8) permits certain retroactive plan amendments that do not reduce the accrued benefits of any participant. ERISA somehow barred the company from giving the particular amendment at issue here retroactive effect.

216, 230 n. 14 (6th Cir. 1980), *aff'd,* 456 U.S. 353, 102 S.Ct. 1825, 72 L.Ed.2d 182 (1982), teach that pendent jurisdiction may be exercised when an interlocutory injunction has been appealed. Given the present posture of the case before us, however, we do not believe that the orderly administration of justice would be furthered materially by addressing the class certification issue at this stage of the proceeding. See *Curran,* 622 F.2d at 230 n. 17.

Plaintiffs have moved to dismiss, for want of jurisdiction, the appeal from the supplemental order in which the district court amended its definition of the class and gave "direction" on implementation of the preliminary injunction. Defendants contend that the supplemental order was one "modifying" the preliminary injunction, and thus is appealable under the express provisions of 28 U.S.C. § 1292(a). We agree that the original injunction was "modified," and that we therefore have jurisdiction as to both appeals.

The motion to dismiss the appeal from the supplemental order is DENIED. The orders granting and modifying the preliminary injunction are REVERSED, the plaintiffs having failed to show the requisite likelihood of success on the issues addressed by the district court, and the case is REMANDED for further proceedings not inconsistent with this opinion.

APPENDIX B

Robert L. Musto, et al.

v.

American General Corporation, et al.

No. 3-85-0546.

United States District Court,
M.D. Tennessee,
Nashville Division.

August 23, 1985.

Retirees brought suit seeking benefits under terms of employee benefit plan established by defendants or their predecessors in interest, declaration of their rights to such benefits, preliminary and permanent injunction prohibiting denial of benefits, and compensatory damages and punitive damages. The District Court, Wiseman, Chief Judge, held that: (1) class action would be certified, and (2) retirees were entitled to preliminary injunction restraining successor employer from implementing changes in medical insurance plan, from enforcing escape clause provision terminating retiree's medical insurance benefits in event that they secured employment with another employer offering medical insurance, and from enforcing modification of spousal survivor benefits offered under predecessor employer's plan.

So Ordered.

Robert L. Ballow, R. Eddie Wayland, Douglas R. Pierce, Mark Floyd, Nashville, Tenn., for plaintiffs.

William C. Humphreys, Jr. Atlanta, Ga., Thomas H. Peebles, III, Nashville, Tenn., for defendants.

MEMORANDUM

WISEMAN, Chief Judge.

This case considers whether an employer (or its successor in erest) can unilaterally terminate or materially alter retirement nefits after employees have provided years of service and have t active employment with the company. The named plain-fs, on behalf of themselves and all others similarly situated, ed this action under the Employee Retirement Income Securi- Act of 1974, [ERISA], 29 U.S.C. §§ 1001-1461, and the ap-icable federal common law, as well as under Tennessee com-on law. Plaintiffs seek: benefits under the terms of employee nefit plans established by defendants or their predecessors in terest, a declaration of plaintiffs' rights to such benefits, eliminary and permanent injunctions prohibiting the denial of e benefits, and compensatory damages and punitive damages. hearing was held on July 29, 1985, through August 1, 1985, to view plaintiffs' motion for class action certification and eliminary injuction. Subject to the conditions set forth in this inion, the Court certifies the case to proceed as a class action rsuant to Fed.R.Civ.P. 23(b)(2) and, also, issues a eliminary injunction.

I. *Findings of Fact*

In 1939 The National Life and Accident Insurance Company lational Life] established an annuity and life insurance pro-am for its employees and future retirees. In 1945 National fe established a health insurance plan for its employees and ture retirees. In 1968 NLT Corporation [NLT] was formed to a holding company for National Life and other affiliated bsidiaries. NLT assumed plan sponsorship for the employee nefit plans established by National Life. All subsidiaries of LT were thereafter covered by the NLT plans. The named aintiffs are all retirees of National Life, NLT or its sub-liaries who receive or were eligible to receive pension and elfare benefits as a result of their service to their former nployer.

The Security Program

a) Its Promotion

The employee benefit plans provided by National Life and NLT were collectively known as the Security Program. The Security Program offered retirees a pension, paidup life insurance and lifetime medical insurance. (Exhibits 18, 19, 20). National Life and NLT used its Security Program as a recruiting device to solicit new agents and also as a bargaining point in attempting to convince its own agents to continue on with the corporation. At this point in the proceeding, it does not appear that all prospective or actual employees were told that retirement benefits were irrevocable or permanently fully "paid up" by the employer, requiring no post-employment premiums. Some individual retirees, however, may have received such representations. (Exhibit 25 — Memo to Cecil Sparkman from Doris Durard, Assistant Secretary, Security Program Division of National Life, responding to specific request for status of retirement benefits: "No contributions required for group life or medical after retirement.").

Over the years, the National Life/NLT Security Program underwent changes, including changes necessitated by the enactment of ERISA. The changes resulted in overall improvements in retirement benefits under the program over the years. (Exhibit 50 and D. Durard Testimony). Among the features of the program were life and medical insurance coverage which continued after retirement and, up until January 1, 1984, required no payment of premiums of the retiree.

National Life maintained its home office in Nashville, Tennessee. However, it maintained and staffed district offices in cities and towns across the country. The district managers and other supervisory personnel were, in addition to being responsible for the selling and servicing of insurance policies, continually required to recruit sales agents for the company. They were also required to counsel employees about the Security Program

ıefits and provide information regarding the Security Pro-
ım.

NLT and National Life utilized the Security Program as a ma-
inducement to attract employees. The promise of continued
ıefits at no cost to the individual after retirement was a
ıterial part of the presentation to prospective employees. Pro-
ɔtion of the Security Program was made both in written
blications and through oral representations by company
ents. Potential employees were advised by brochures,
mstrips, and audio recordings, as well as by the representa-
ns of recruiters, that the Security Program was one of the
ɔst liberal benefit packages in the country. (*See e.g.*, Exhibits
and 22. "You pay absolutely nothing into this outstanding
irement plan. The company pays all the cost. It's National
fe's way of saying "thank you" for years of loyal service, and
think it's a good way.").

NLT and National Life also utilized the Security Program as
inducement to persuade employees to remain with the com-
ny rather than going to work for competitors or other
ɔloyers. The testimony of witnesses who held district
ınager and other higher management positions indicates that
enever a good employee was considering leaving the Com-
ny, he or she would be reminded of the excellent retirement
ıefits available from National Life or NLT. Management
uld emphasize the fact that medical and life insurance would
ıtinue at no cost after retirement. The Security Program was
ponsible, at least in part, for retaining a productive and
iable work force for NLT and National Life.

At least once yearly all NLT and National Life employees
eived a personal statement setting forth the benefits each in-
idual employee was entitled to receive under the Security
ɔgram. These personal statements of benefits addressed both
esent benefits and future benefits after retirement. Further,
ese statements emphasized that the employees would not be

required to contribute for continued life and medical insurance coverage after retirement. (Exhibit 11). Pursuant to Company instructions, managers reviewed the annual statements with all their subordinates emphasizing the present and future benefits provided by the Company. (R. Musto and G. Laurence Testimony).

In district meetings held generally on a monthly basis, sales agents of the district were reminded of the Security Program and its retirement benefits with the promise of continued life and medical insurance coverage at no further cost. Also, at least three or four times a year all field employees were shown a special audio-visual presentation on the Security Program. This presentation emphasized the major features of the program, including retirement benefits and continued medical and life insurance at no cost.

National Life and NLT maintained a chain of command to assure the uniform administration of and dissemination of information concerning the Security Program. Corporate protocal required employees to go to their district manager if they had a question concerning benefits. (K. Sanders Testimony). Home office correspondence to field employees concerning their benefits was sent to and distributed by the district manager. (Exhibit 25). Whenever an improvement was made to the Security Program for retirees, district managers were imformed so that they could in turn show employees that NLT was taking care of its retirees. (Exhibit 7).

In addition to recruiting materials, film strips and other materials, NLT and National Life furnished employees summary booklets every several years that set forth the Security Program provisions, including the provision of continued benefits at no cost after retirement. (Exhibits 5, 18, 19 and 20). NLT and National Life also regularly printed official company publications for its employees which, on at least two occasions, provided detailed information about the Security Program, in-

ing the fact that retirement benefits were furnished at no to the retiree. (Exhibits 8 and 9).

nally, in numerous other communications to employees, onal Life and NLT emphasized the benefits available after ement under the Security Program. For example, general ces were sent to employees which referred employees to the mary booklet provisions concerning continued life and ical coverage at no cost after retirement. (Exhibit 6). onses to employee inquiries regarding anticipated retire- benefits reaffirmed this no cost feature. (Exhibit 25). In tion, applicants for disability retirement were issued a state- promising medical and life insurance benefits at no cost retirement. (Exhibit 30).

short, National Life and NLT aggressively promoted the ection it would give its employees and retirees. The promise ntinued benefits at no cost after retirement was continually firmed in various ways.

Termination/Modification Clauses

ne problem in this case arises because at the same time NLT National Life were promising retirement benefits at no cost employees, the corporations were including in certain im- ant documents termination/modification clauses that ved to the companies the right to amend or rescind the pro- d benefits. Among the documents introduced at the hear- he Court identifies three types of documents which contain ermination/modification clauses:

rst, a right to change or terminate medical and life in- nce appeared in the official master plan documents or ies. (Exhibit 48). These documents, however, were not buted to employees, nor were they readily available.

cond, individual certificates of insurance for life and cal insurance issued to active employees indicated that rage could be terminated. (Exhibits 24 and 46). At retire-

ıent, a retiree was issued a new certificate for his post-mployment years which also reserved to the company the right o amend or terminate the promised benefits. (Exhibit 47).

Third, the company distributed summary booklets every few ears which explained the medical and life insurance benefits vailable both before and after retirement. (Exhibits 18, 19, 0). After the enactment of ERISA, the booklets were referred o as summary plan descriptions. (Exhibit 2). Prior to 1977, the ooklets typically contained the following clause:

> The Group Insurance provisions of the Security Program have been arrived at after careful study, and it is the Company's expectation that they will be continued indefinitely. However, since it is not possible to foresee the future, the Company must reserve the right to change or even discontinue these provisions if it becomes necessary. (Exhibit 18).

ı 1977 the clause was changed to read:

> The Company fully intends to continue the Plan indefinitely and to meet any foreseeable situations which may occur. However, the Company does, as it always has, reserve the right to change the Plan and, if necessary discontinue it. (Exhibit 5).[1]

c) *Amendment of Medical Insurance Benefits*

The right to "paid up" medical insurance coverage is promis-d in relevant provisions of the 1977 Group Insurance Plan (Ex-ibit 5 at p. 23):

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[1] At the hearing, the defendants focused attention on the change in e meaning created by the placement of the term "if necessary" as a odifying clause to the company's right to discontinue the plan. efore 1977, the "if necessary" qualification applied equally to nendments and terminations of the plan. Defendants argue, erefore, that after 1977 the defendant need only show cause prior to an termination and that amendments may be made at will.

prehensive Medical Expense Insurance

ter your retirement under the Company's Retirement an, Comprehensive Medical Expense Insurance coverage ll continue on you, and on your spouse if your spouse s been covered immediately prior to your retirement date . . .

* * * * * *

o contributions are required for continued coverage on u and your spouse after retirement . . . .

ooklet was prepared for and distributed to active ees as well as to retirees.

ican General Corporation [American General] acquired n November 4, 1982. American General is a Texas cor- n that is the parent of a number of other insurance com- Defendants currently are responsible for the ad- ation of plaintiffs' pension and welfare plans.

e merger agreement and elsewhere, American General to maintain existing NLT employee benefits, including urity Program, in effect at the time of the merger.[2] The or further promised that if it integrated NLT's benefit ns with existing American General programs, American would provide NLT's employees with overall benefits able to those in effect at the time of the merger. Similar , American General was self-insured with respect to the rance and medical benefit plans.

the corporate merger and until December 31, 1983, Na- ife and NLT provided their retirees and the retirees'

ntiffs made this allegation at the hearings and in their s, yet no direct evidence was presented at the hearing. r, defendants, while objecting to this finding because no has been presented, do not deny that it is true.

spouses with medical insurance having a lifetime maximum benefit of $100,000.00 per person after retirement. The medical insurance had an annual deductible of $100.00 per person. The insurance plan paid 100% of a person's surgical fees. It also paid 100% of the first $3,000.00 of hospital expenses and 80% of hospital expenses over that amount. A retiree and his spouse or dependants were required to pay no more than $500 in a calendar year, in addition to the per person deductible. This feature is referred to as a "maximum annual cost." Finally, the retiree was not required to make any further contributions to be eligile to receive this insurance.

NLT was self insured. The master insurance policy covering its life and medical insurance plans, including the provision for continued coverage after retirement, was with NLT's wholly owned subsidiary, National Life. According to the National Life Form 5500, Annual Report of Employee Benefit Plans, for the 1983 calendar year, NLT reported to the Internal Revenue Service that $42,263,925 constituted policyholder reserve "held to provide benefits after retirement," under the NLT Security Program. (Exhibit 27). Claims reserves in the amount of $208,005 were also maintained.

In November 1983, American General conducted numerous meetings at locations across the country for active employees formerly employed with NLT or its subsidiaries. The meetings were intended solely for current employees. Individuals who had already retired were not invited. At the meetings as well as in documents and other communications, defendants informed employees that on January 1, 1984, changes would be made in future retirement benefits. Employees were informed that after January 1, 1984, they would fall under the American General plan. (Exhibit 33). Hence, those employees who retired after January 1, 1984, would receive retirement benefits under the American General benefit plan, whereas those electing retirement prior to January 1, 1984, would come under the

NLT/NLA plan.[3] The employees, which included a number of plaintiff retirees who had not yet retired at that time, were told they would not suffer any losses under the American General plan but would "get the best of both worlds."

By coming under the American General plan, the former NLT/NLA employees (now American General employees) realized the folowing changes from their former benefits under the NLT/NLA plan: An increased lifetime maximum benefit to $750,000.00 per person. The "up front" costs for a future retiree, his spouse and dependants, however, were increased. The January 1, 1984, plan offered three options of "up front" costs. The annual deductible per person was $275.00, $200.00 or $125.00. The maximum annual cost was $1,500.00, $1,000.00, or $1,000.00 per person and $2,500.00, $2,000.00, or $1,500.00 per family respectively. Additionally, surgical and hospital costs were reduced from 100% to 80%. Retirees leaving employment after January 1, 1984, would be required to make contributions to receive medical insurance. The dollar amount of monthly contributions varied depending upon the retiree's age, whether he elected to have coverage for dependants, and which of the three plans was chosen. Individuals who elected early retirement were told that they would have the same coverage and at the same cost as active employees. (Exhibits 33, 36 and 37). Contributions for those retirees over age 65 were lower since their benefits were coordinated with Medicare. All retirees contributed approximately 20% of the cost of their chosen insurance.

During the November 1983 meetings defendants represented that those employees who retired before January 1, 1984, would

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[3] As discussed below, this distinction warrants the certification of two subclasses in this case. Subclass A constitutes those retirees who left active employment prior to January 1, 1984, and therefore fall under the NLT/NLA retirement benefit plan. Subclass B constitutes those retirees who left active employment after January 1, 1984, but prior to the changes put into effect on July 1, 1984.

receive the same level of pension and welfare benefits, including medical insurance, as had been promised under the NLT Security Program. Neither during these meetings nor at any other time were plaintiffs orally advised that the insurance benefits would or could be reduced. As had been the NLT practice, the express reservation was made only in the plan documents identified above. Testimony indicated that company agents advised employees of the termination clause only if directly asked a specific question on the policy term. Paraphrasing the words of one such agent "you do not emphasize the negative."

A number of the still actively employed plaintiffs relied on defendants' representations regarding planned future changes in benefits. Some plaintiffs retired prior to January 1, 1984, so that they could receive the benefits provided under the NLT Security Program. Other plaintiffs decided not to retire but to remain as active employees and retire under the promised benefits plan which was to become effective on January 1, 1984.

Commencing on January 1, 1984, defendants began providing the welfare and pension benefits promised in November 1983 to those plaintiffs who retired on or after January 1, 1984. These pre-January 1, 1984, retirees continued to receive the same level of retirement benefits earned under the NLT Security Program.

In May 1984 defendants notified all plaintiffs who had retired before May 1984 (both pre- and post-January 1, 1984) that certain welfare retirement benefits would be changed effective July 1, 1984. (Exhibit 14). Six months after January 1 changes were put into effect. American General changed the plan again.[4] Plaintiffs were sent an election form giving them the option to

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[4] This fact is important with respect to those plaintiffs who were active employees during the 1983 meetings during which they were put in a position of deciding whether to retire before January 1, 1984, under the NLT/NLA plan or after January 1 under the American General plan.

enroll in the new plan at the stated cost and level of benefits or to reject the plan and "not participate," that is, to give up their insurance altogether. (Exhibit 26). Active employees who had requested retirement in May and June 1984 were notified of the changes after they applied for retirement. Other active employees were not advised of these changes until late June 1984. Also in May 1984, defendants announced a change in pension benefits. (Exhibit 35).

The July 1, 1984, medical insurance program, applied to *all* retirees, regardless of their retirement date. The plan provided a lifetime maximum benefit of $200,000.00 per person. (Exhibits 14 and 15). All plaintiffs were required to pay "up front" costs of an annual deductible of $200.00 per person and a maximum annual cost of $1,000.00 per person and $2,000.00 per family.

The July 1, 1984, changes eliminated the "paid up" policy under the NLT/NLA plan. All plaintiffs were required to make contributions for continued insurance coverage or permanently forfeit any and all retirement medical insurance benefits. Retirees under age 65 were required to contribute 25% of the cost of the insurance.[5] Retirees 65 and older were required to contribute 50% of the cost. Because of the coordination with Medicare for those over 65, the costs for all retires was roughly the same. American General had determined that the claims made by retirees was not met by contributions, thereby placing a disproportionate burden on active American General employees to fund the medical insurance plan. (Testimony of Mr. Tuerff).

As a result of defendants' July 1, 1984, action, all named plaintiffs and members of the class they seek to represent, regardless of their retirement date, are receiving the same level of medical insurance benefits. Approximately 230 retirees or spouse survivors out of a putative class of at least 1,800, eligible

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[5] Defendants had intended to increase the contribution of retirees under age 65 to 50% on July 1, 1985; this court temporarily restrained such action on June 26, 1985.

to enroll in the American General Retiree Medical Plans "chose" not to enroll. At this point in the proceeding the Court cannot determine how many of these people chose not to enroll because the cost was prohibitive. (Exhibit 41).

d) *Escape Clause Provision for "Other Insurance"*

Another feature of the July 1, 1984, modifications was that if any retiree or his or her spouse was eligible as an employee for another employer's group medical insurance, then defendants would permanently cancel all medical insurance under the American General program for that retiree or spouse. (Exhibit 43). This escape clause applied even if a retiree or spouse elected not to be covered by the other employer's medical insurance. As of July 1, 1984, eight persons had been terminated pursuant to the "other insurance" provision. (Exhibit 43).

The program of medical insurance provided by National Life or NLT and the programs enacted by American General on January 1, 1984, were not subject to such a provision. Under previous plans, any insurance from another employer would be coordinated with the retiree medical insurance.

e) *Spousal Survivor Benefits*

Spousal survivor pension benefits allow a retiree, by electing a smaller present monthly benefit, to provide his or her surviving spouse with one-half the retiree's level of pension benefits upon the retiree's death. Under the NLT program retirees were able to enjoy their full pension benefit amount until age 65, at which time an election was required and contributions would begin. The NLT Pension Plan permitted those employees who retired before age 65 to defer election and contributions until reaching age 65.

After acquiring NLT, American General initially maintained the NLT/NLA spousal benefit election formula. (Exhibit 34). In May 1984, however, defendants notified all plaintiffs who either had taken or had applied for early or disability retirement

after January 1, 1984, that they could not wait until age 65 to make an election; rather, the election was required immediately, together with immediate contribution toward the spousal survivor benefits (Exhibit 35). At no time before the May 1984 change did defendants advise plaintiffs that such a change would be forthcoming. (Exhibit 35, May 14, 1984 letter).

Based on these facts, the Court makes the following determinations with respect to (1) class certification and (2) preliminary injunction.

II. *Conclusions of Law*

A. *Class Certification*

The Court finds that the evidence presented at the hearing supports the certification of a class action in this matter. The case shall proceed as a class action pursuant to the provisions under Fed.R.Civ.P. 23(b)(2). All prospective members in the class shall be given written notice of the contemplated action, specifically delineating the nature of the action, the relief sought, the types of benefits and obligations a prospective class member would be entitled to should they opt out and continue under American General's present plan, and any other information material to class notification.

In opposing the procession of the hearing on the preliminary injunction and on class certification, the defendants challenge the propriety of a ruling on a preliminary injunction prior to a decision on class certification. Defendants maintain that no decision on the merits of the case should be made prior to class certification. Defendants argue that the issuance of preliminary injunction constitutes "the decision on the merits." The Court concludes that a hearing on class certification and on preliminary injunction may be held simultaneously. Fed.R.Civ.P. 23(c)(1) provides:

> As soon as practicable after the commencement of an action brought as a class action, the court shall determine by

> order whether it is to be so maintained. An order under this subdivision may be conditional, and may be altered or amended before the decision on the merits.

The hearing on class certification in this matter was held at the soonest practicable opportunity after the filing of the case. This Court entered a temporary restraining order on June 26, 1985. Under Fed.R.Civ.P. 65(b), the duration of a temporary restraining order is limited to ten days, unless the time is extended for good cause. Because of scheduling difficulties and by agreement of the parties, the Court did not hold a hearing on a preliminary injunction until July 29, 1985. In holding a consolidated hearing on both the class certification and the preliminary injunction, the Court was meeting the requirements both of Rule 65 and Rule 23.

The defendants' position miscontrues the requirements under Rule 23(c)(1). The first sentence sets forth the temporal guidelines for the Court, requiring a hearing on class certification "as soon as practicable." The second sentence permits the Court to issue a conditional order or to alter or amend the order before a dicision on the merits. The second sentence, however, does not require certification of a class prior to any and all substantive injury; it merely requires that if a class certification order is to be altered or amended it must be made before the decision on the merits.

The issuance of a preliminary injunction does not involve " '*THE*' decision on the merits." Rather, it represents a provisional determination made after a preliminary consideration of only a portion of the evidence available. Rule 23's reference to "the" decision on the merits connotes a final decision resolving the central issues of law and fact in the case, thereby defining the rights and obligations of the parties. A decision on a preliminary injunction is an interlocutory order, rendering provisional, extraordinary relief pending a full hearing and "the" decision on the merits.

This Court does not believe that it must hold two separate hearings at different times to determine issues of class and those relating to a preliminary injunction. The interests in judicial efficiency dictate that a court resolve such issues as early into the proceeding as possible. In this case, the Court was able to provide the parties four full court days during which to establish matters pertaining to class and to the preliminary injunction. The consolidated hearing avoided the unnecessary duplication of evidence, permitting the Court to resolve both issues in a single proceeding.

1. *Plaintiffs Have Demonstrated the Four Elements Necessary to Maintain a Class Action.*

Plaintiffs seeking to certify their suit as a class action must demonstrate the four prerequisites under Fed.R.Civ.P. 23(a): numerosity, commonality, typicality, and adequacy of representation. Upon consideration of the evidence, the Court is satisfied that the plaintiffs have met their burden in demonstrating these elements.

a) *Numerosity.*

Under the direction of a number of former NLT/NLA officers and managers, principally under the direction of Mr. Robert Musto, an association has been created comprised of retired persons from NLT/NLA. The association is known as NLTR. This group has actively solicited membership and contribution from all NLT/NLA employees. Response generally has been favorable. (Exhibit 17)(letters in response to NLTR solicitations). According to the testimony of Mr. Musto, over 1800 former employees have been solicited through the mail. The Court finds that the prospective class is so numerous as to make joinder impracticable. The requirement of numerosity is satisfied.

b) *Commonality.*

The issues of law and fact are common to the class. All retirees are treated under the same terms of the current plans regardless of when they retired. (E. Bottiggi testimony.) The claims all concern rights and obligations arising out of the employee benefit plans offered by NLT/NLA, with common issues of law arising under ERISA concerning the enforceability of those rights.

c) *Typicality.*

The Court finds that the claims of the representative party are typical of the claims of the class. Defendants argue that because the plaintiffs claim that their entitlement to continuation of paid up medical insurance policies rests on reliance on certain oral representations and individual written correspondence, each individual plaintiff presents a different set of facts requiring the Court's specific attention. While the Court recognizes that the particular representations made may, in some cases, differ between individual class members, the central material inquiry in this case concerns the long term, centrally directed campaign by NLT/NLA to solicit and retain employees with the inducement of the Security Program. The principal evidence of the promotional use of the Security Program consists of widely disseminated written materials (e.g., Exhibits 18, 19, 20) presented to the class as a whole. Although individual agent's representations may have differed, the company's aims and approach were uniform. Because the Court has the authority to alter or amend the class certification order, should it appear on a full hearing of the merits that unique circumstances surrounding certain representations and individuals' reliance exist, the Court may order that those issues be severed and considered separately from the class issues.

d) *Adequacy of Representation.*

The representative parties possess sufficient financial resources to maintain this action. Mr. Robert Musto testified

at NLTR had thus far raised over $100,000 to support the al effort. Class representatives have retained competent unsel. Because of the similarity in all class members' position -a-vis American General's treatment of their retirement nefits, the Court concludes that the representative parties ve sufficient common interest with the unnamed members of e class and will vigorously prosecute the case to protect those erests. *Senter v. General Motors Corp.*, 532 F.2d 511, 4-525 (6th Cir.), *cert. denied*, 429 U.S. 870, 97 S.Ct. 182, 50 Ed.2d 150 (1976).

The class action is maintainable under the provisions of (b)(2). That section provides:

> the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole.

fendant does not dispute that it has acted uniformly in its atment of all retirees retirement benefits. The same issues of v apply to all retirees (subject to the distinction drawn bet- en the subclasses outlined below).

Pursuant to the provisions under 23(d), the Court finds it ap- opriate to order the representative parties to give notice to all ospective class members permitting those class members who ire to opt out of the class action to do so. Because under the pposed new terms of the American General policy, certain nefits may be deemed more favorable, although premiums l increase, certain members may seek those additional nefits. Prospective class members should have the opportuni- o decide whether to participate in seeking the relief sought by ss representatives or to accept the amendments sought to be into effect by American General. Class notification should vide all class members with an impartial account of their op- ns under both the plan sought by the representative party and t offered by American General.

In certifying the class, the Court also certifies two subclasses pursuant to the provisions under 23(c)(4). Subclass A consists of all those retirees who left active employment prior to January 1, 1984. Subclass B consists of all those retirees who retired or were qualified but had not yet retired after January 1, 1984, but before July 1, 1984. Plaintiffs in Subclass A seek the level of retirement benefits offered as of December 31, 1983. Members of Subclass B seek the level of retirement benefits offered as of June 30, 1984. The level of benefits between Subclass A and Subclass B differs and there also may be certain differing facts concerning representations made to the members of Subclass B regarding amendments of the benefit plan. The representations and treatment of all members of both classes, however, is sufficiently common for all members to proceed in the same action.

B. *Preliminary Injunction*

Four principal factors are crucial to the determination of whether to issue a preliminary injunction in a civil case: (1) the likelihood of success on the merits; (2) the likelihood of irreparable harm absent such extraordinary relief; (3) the impact on the public interest; and (4) the possibility of substantial harm to others. *Christian Schmidt Brewing Co. v. G. Heileman Brewing Co.*, 753 F.2d 1354, 1356 (6th Cir.), *cert. dismissed*, ____ U.S. ____, 105 S.Ct. 1155, 84 L.Ed.2d 309 (1985). The Court finds that the plaintiffs have satisfied each of the four elements to warrant this Court's issuance of a preliminary injunction. The Court therefore restrains defendants (1) from implementing changes in the medical insurance plan that were to go into effect as of July 1, 1985, (2) from enforcing the escape clause provision terminating retirees' medical insurance benefits in the event that they secured employment with another employer offering medical insurance (persons so terminated shall be reinstated), and (3) from enforcing the May 1984 modification of spousal survivor benefits offered under the NLT/NLA plan. The preliminary injunction is aimed at maintaining the *status quo*.

Likelihood of Success of the Merits.

ıe Court approaches analysis of this issue keeping in mind principal policy objective of Congress in enacting the loyee Retirement Income Security Act. That is, the need to guard employees' retirement income from unforeseeable, rary and capricious reductions or modifications by former oyers and others. H.R.Rep. No. 93-533, 93rd Cong., 2d , *reprinted in* 1974 U.S.Code Cong. & Ad. News 4639-40. loyees must be able to rely on the promises made by their oyers regarding retirement benefits so they can reasonably ict the level of anticipated future sources of income and by formulate a responsible plan of financial support for postemployment days.

RISA Preempts the Plaintiffs' State Law Claims.

e plaintiffs have stated a number of state law claims for epresentation and breach of contract under the common of Tennessee. As to these claims, the Court finds that the tiffs have no likelihood of success on the merits. ERISA npts state law provisions concerning employee benefit , federalizing the area of pension right and related an- y welfare benefits by establishing uniform standards of responsibility for the administration of such plans. Rep. No. 93-533, 93rd Cong., 2d Sess., *reprinted in* 1974 Code Cong. & Ad.News 4639, 4639-40; *Alessi v. estos-Manhattan, Inc.*, 451 U.S. 504, 523, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981); *Adcock v. Firestone Tire & Rub- Co.*, 616 F.Supp. 409 (M.D.Tenn. 1985).

RISA's Statutory Framework

e Court considers here two principal types of benefits at the retirees' medical insurance benefits and the spousal vor benefits. The former benefits are offered under a re benefit plan, while the latter are offered under a pension Pensions are a form of deferred compensation to which

an individual employee accrues rights by providing a period of service to a particular employer. Pensions provide the employee a secured measure of income following his retirement from active employment, thereby assuring a source of economic resources during one's later years of life. Welfare benefit plans, on the other hand, are not necessarily intended as deferred income to assure economic stability during one's post-employment days. Rather, the plans often serve as a form of deferred, frequently contingent, benefit that is offered by virtue of one's affiliation as an employee of a certain employer. 29 U.S.C. § 1002(1) and (2); *Adcock*, at 413-14 (severance pay benefits). However, in this case, the retiree medical insurance plan would constitute a welfare benefit offered as a non-monetary form of past-employment, deferred income.

Under ERISA, an employer often wears "two hats." On one hand, the employer devises and offers certain employee benefit plans as an incentive to his employees to remain with the company and to provide quality service. In this role, the employer formulates non-wage compensatory benefit plans and funds them out of its assets. The other role assumed by the employer usually is that of a fiduciary. Under ERISA, the administrator of an employee benefit plan is held to fiduciary standards of care in the administration and management of plan assets. 29 U.S.C. § 1101, *et seq*. Part of the employer/fiduciary's duties consist of compliance with the reporting and disclosure provisions under ERISA, 29 U.S.C. §§ 1021-31, which mandate the distribution of information concerning individual benefits under employee benefit plans.[6]

In this case, the Court is faced with the unusual situation in which the defendant employer wears three hats. American General is the (*successor*) employer formulating the employee

[6] The Court at this point does not consider the claim of Mr. Musto regarding alleged violations of the reporting and disclosure provisions of ERISA.

t plans; the fiduciary charged with the administration and
ement of the employee benefit plans;[7] and, third, with
to the medical insurance plans, the insurance carrier
vhom American General, as employer, has "purchased"
nce policies so as to honor the welfare benefit plan obliga-

e Court refrains from referring to American General as
e" of the medical insurance plan, but uses the term "ad-
ator" instead. ERISA normally requires that benefit plan
e held in trust by a person named fiduciary. 29 U.S.C. §
. However, the requirement that such a trust be established is
licable to assets of an insurance company or assets of a plan
an insurance company. 29 U.S.C. § 1103(b)(2). In this case,
olicy reserves dedicated to the medical insurance plan con-
assets held by the fiduciary for the plan beneficiaries, these
re not held in trust. "[A]ssets placed in a separate account
d by an insurance company are separately managed . . . in-
companies are to be responsible under the general fiduciary
th respect to assets held under separate account contracts, and
ts of these contracts are to be considered as plan assets (but
t be held in trust)." H.R.Conf.Rep. No. 93-1280, 93rd Cong.,
., *reprinted in* 1974 U.S.Code Cong. & Ad.News 5038, 5077.
urt construes the master policy documents introduced as
e at the hearing to constitute separate account contracts. At
r 1983 purposes, the assets held as reserves for such contracts
an amount exceeding $42,000,000, as indicated on the Form
tional Life submitted to the IRS. Fiduciary standards of care
the administration of these assets. As to the pension plans,
r, and in particular spousal survivor benefits, American
occupies the position of *trustee*.

tions.[8] As employer, the Court will look to the obligations assumed by American General as the successor corporation to NLT and National Life regarding the funding of the disputed employee benefit plans. With respect to American General's fiduciary duties as administrator of the employee benefit plan assets, the Court will consider what obligations flow from its fiduciary duties in the management of the fund assets dedicated to the welfare benefit and pension plans, if any. Third, the Court will make limited observations concerning American General's role as the insurance carrier for the plans. The Court views this role as merely complying with Tennessee state law regulating an insurer's duty to assure proper reserves for the potential payment on insurance claims.

c) *American General's Funding Obligations as the Corporate Successor to the Plaintiffs' Former Employer.*

(1) *Medical Insurance Plan*

The principal consideration here concerns whether American General, in light of a four-fold increase in the cost of the medical insurance plan during the last five years, has the right to invoke the termination/modification clause contained in the employees' welfare benefit plan and thereby modify the terms of the present plan, increasing the retiree's deductible and premium costs while, in some respects, reducing the level of benefits offered. (*See* Exhibit 50). The issue is made particularly difficult in view of the gap in ERISA's statutory regulation

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[8] The Congress recognized this "third role" assumed by self-insured insurance companies which offer employee insurance plans.

> [I]t would be contrary to normal business practice to require the plan of an insurance company to purchase its insurance from another insurance company. This exemption is available only if no more than adequate consideration is paid for the insurance by the plan.

H.R.Conf.Rep. No. 93-1280, 93rd Cong., 2d Sess., *reprinted in* 1974 U.S.Code Cong. & Ad.News 5038, 5094.

concerning the legal status and enforceability of welfare benefit plan rights. Unlike pension plan rights, which are subject to elaborate vesting, participation, and funding provisions mandating minimum asset structure standards, 29 U.S.C. §§ 1051-86, welfare benefit plan rights are expressly exempted from these requirements. An employee therefore can "accrue" no "vested" right to medical insurance benefits. Defendants argue, therefore, that they are entitled to terminate or amend plaintiffs' level of benefits subject to the written terms of the plan, that is — at will. The Court disagrees.

(2) *Policy Under ERISA*

It would be contrary to the spirit of ERISA to hold that rights promised welfare benefit plans are mere gratuities terminable at the will of the employer. The defendants contend that welfare benefits may be amended at American General's discretion so long as the plan contains an unqualified modification/termination clause. The argument is antithetical to the policy objectives of ERISA. Congress has sought to fortify retirement income -- not by mandating that individuals get more of it — but by seeking to assure that such income provide a reliable predictable source of financial support. Once an employee has rendered his years of service to the employer, his "sweat equity," and has taken retirement, the employee furnishes little to the employer that generates revenue; hence, the employer may perceive little risk in reducing the level of benefits previously promised. Since an active employee generates revenues beyond his wage and costs of overhead, he possesses the economic leverage to bargain for benefits. Freedom of the employee to leave — and with him the profits he generates, imposes a check on the employer's temptation to trim costs by reducing employee benefits. The employer who amends the company vacation policy reducing annual vacation days from two weeks to two days will experience a mass exodus of his labor pool. But, the employer who doubles the medical insurance premiums for his retirees will receive the increased monthly checks from all those who can

afford it and cannot find an adequate substitute source of protection.[9] The retirees have no economic leverage, hence no bargaining position to check modifications of benefits made solely in the interest of their former employer.[10] To permit the enforcement of termination/modification clauses without a showing of good cause has the effect of reducing the status of hard earned welfare plan benefits to mere gratuities. Accurate financial forecasting or retirement planning is impossible because continuation of the benefits is subject to the discretion of an employer. The exercise of such discretion without a "for cause" standard cuts against Congress' intent to safeguard these retirement benefits.

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[9] And while active employees undoubtedly will be displeased with a doubling of their medical insurance premiums, they nevertheless are in a position to bargain with their employer to maintain current premiums. When the employer's action is deemed too drastic and the employer is unresponsive to employee protests, ultimately employees will leave. That another worker may step in at the lower benefit is immaterial — for that event is a "healthy" result of the principles of supply and demand in a competitive market — the paramount factor is that the active employer/employee relationship permits bargained for exchange. In the employer/retiree context, the retiree has no leverage (with the exception of ancillary effects on the employer's public image and active employee morale), hence arm's length negotiation frequently may not occur.

[10] American General's recognition of the retiree's lack of bargaining leverage is represented in the manner in which it approached the January 1, 1984, amendments. The corporation sent out fifteen to twenty teams to make nationwide presentations to *active* former NLT/NLA employees concerning the merger of the NLT Security Program into American General's. No retirees were invited; some were discouraged from attending. American General was concerned with maintaining the good will and services of the active employees, but, as to the retirees, this group had little to offer, hence unilateral changes made on a "take it or leave it" basis posed no prospect of substantial loss to the company. The presentations made to active employees take on the appearance of a bargained-for exchange. The unilateral amendments to the retiree's benefits do not; they reflect overreaching.

(3) *Formulation of a Rule of Federal Common Law*

Interpretation of the legal status and enforceability of plaintiffs' medical insurance plan is governed by principles of federal common law. As this Court held in *Adcock*, although welfare benefit plans are not subject to the vesting and participation provisions of ERISA, an employee nevertheless may acquire a contractual interest in such benefits, enforceable under federal common law. *Adcock*, at 415. "Congress intended that a body of Federal substantive law . . . be developed by the Court to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong.Rec. 29942 (1974) (remarks of Senator Javits). *See Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc.*, ____ U.S. ____, 105 S.Ct. 2833, 2840-41, 86 L.Ed.2d 447 (1985). In a concurring opinion to the decision in *Massachusetts Mutual Life Insurance Company v. Russell*, ____ U.S. ____, 105 S.Ct. 3085, 3098, n. 18, 87 L.Ed.2d 96 (1985) (Brennan, J., concurring), Justice Brennan noted:

> "Where the courts are required themselves to fashion a federal rule of decision, the source of that law must be federal and uniform. Yet, state law where compatible with national policy may be resorted to and adopted as a federal rule of decision . . . . Here, of course, there is little federal law to which the court may turn for guidance. State regulation of insurance, pensions, and other such programs, however, provides a preexisting source of experience and experiment in an area in which there is, as yet, only federal inexperience . . . . State statutory sources of law will no doubt play a major role in the development of a federal common law under ERISA, particularly in defining rights under employee benefit plans." *Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 426 F.Supp. 316, 325 (N.D.Ind.), *modified on other grounds*, 567 F.2d 692 (7th Cir. 1977).

The Court looks to the state common law of contracts as guidance in formulating a sound federal common law rule with which to analyze the rights and obligations of the parties. In *In re White Farm Equipment Co.*, 42 B.R. 1005 (Bankr.N.D.Ohio 1984), *expedited appeal granted* (April 15, 1985), *suggestion of bankruptcy filed staying appeal* (June 24, 1985), Judge Aldrich decided a case remarkably close on point to the issues pending in this matter.[11] Retirees of the corporation had commenced the action under the Bankruptcy Act seeking retroactive reinstatement of welfare benefits, including health, life and welfare insurance, following termination of the benefits by a successor corporation to the retiree's former employer. The Bankruptcy Court had entered summary judgment in favor of the employer, finding that Congress had expressly excluded welfare benefit rights from the vesting and participation standards of ERISA, 29 U.S.C. § 1051, and therefore excluded such benefits from the concept of "accrued benefits," 26 C.F.R. § 1103(1)(2), thereby permitting the corporation's unilateral termination of the retiree's rights. In reversing the Bankruptcy Court, Judge Aldrich stated that "nothing in ERISA indicates that Congress intended to make contracts unenforceable," 5 EBC at 2139. The district court proceeded to consider Ohio law as well as that of other states in defining employee benefit rights. The court concluded that:

> an employer may not invoke a termination clause to cut off the benefits of a former employee who has properly retired pursuant to the employer's requirements . . . .

This Court agrees with the analysis in the *White Farm Equipment* case, that is, that the legal status of the benefits should be

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[11] Defendants concede that if the holding in *White Farm Equipment* is "good law," then this Court must find in favor of the plaintiffs. Defendants ask the Court to review carefully the analysis of the case and refuse to follow its holding. This Court views *White Farm Equipment* as "good law."

construed consistent with ERISA's policy and state contract law concerning (1) unilateral contracts and concepts of substantial performance and bargained for exchange, and (2) determination of the intent of the parties to resolve conflicting and ambiguous terms contained in plan documents. *See United Steelworkers of America v. North Bend Terminal Co.*, 752 F.2d 256, 259 (6th Cir. 1985).

The creation of a binding contract requires an offer and acceptance, both of which are supported by adequate consideration. Similarly, the modification of a contract requires a bargained-for exchange supported by consideration. In *Simmons v. Hitt*, 546 S.W.2d 587, 592 (Tenn.App. 1976), the Tennessee Court of Appeals held that unfunded pension and retirement plans are not merely gratuities offered by the employer, but created legal rights upon the employees' notice that such benefits are being offered and the employees' performance of the terms necessary for acceptance. The *Simmons* court stated:

> We hold a non-contributing pension plan is not a gratuity. It is an offer of additional deferred compensation to the employee as an incentive toward continuing better service and loyalty; the offer is accepted by the employee remaining in the employment of the employer, which is sufficient consideration to support the employer's promise to pay the benefits and is therefore a contract enforceable by the employee.

Id. at 592, *quoting Johnson v. Mueller Co.* (1974) (Matherne, J., unreported). In this case, NLT/NLA management consistently promoted its Security Program as a form of deferred compensation in consideration of present service with the company which, although yielding no present monetary benefit, would ultimately guarantee financial security during retirement.

In defining the rights of the parties, the Court first will consider the explicit language contained in plan documents. *International Union v. Yard-Man, Inc.*, 716 F.2d 1476, 1479-80 (6th

Cir. 1983), *cert. denied*, ____ U.S. ____, 104 S.Ct. 1002, 79 L.Ed.2d 234 (1984) (interpreting the terms of a collective bargaining agreement under the Labor Management Relations Act).

> The intended meaning of even the most explicit language can, of course, only be understood in light of the context which gave rise to its inclusion. The court should also interpret each provision in question as part of the integrated whole. If possible, each provision should be construed consistently with the entire document and the relative positions and purposes of the parties. As in all contracts, the collective bargaining agreement's terms must be construed so as to render none nugatory and avoid illusory promises. Where ambiguities exist, the court may look to other words and phrases in the collective bargaining agreement for guidance . . . . Finally, the court should review the interpretation ultimately derived from its examination of the language, context and other indicia of intent for consistency with federal labor policy. This is not to say that the collective bargaining agreement should be construed to affirmatively promote any particular policy but rather the interpretation rendered not denigrate or contradict basic principles of federal labor law.

Id. at 1479-80. (citations omitted). The termination/modification clause contained in the NLT/NLA summary plan descriptions clearly and expressly reserve the right to amend and terminate the medical insurance benefit plan. At the same time, however, the plan descriptions also promise to continue the plans after the plaintiffs' retire, without further cost to the retiree. The Court cannot read both provisions together without reaching the conclusion that the provisions conflict and require interpretation of what the parties mutually intended by placing the terms in the agreement. As stated in *Yard-Man*, the agreement's terms must be construed to avoid nugatory and illusory promises. To read the plan as providing lifetime paid up

medical insurance and, at the same time, reserving the right to terminate the benefits at any time constitutes an illusory promise — an express, unqualified grant of a right negated by an express unqualifed reservation of the right to terminate the grant.

The Court does not believe that the promise of medical insurance benefits is a mere gratuity, but rather a legal right derived from a unilateral contract. The plaintiffs in this case were promised that if they became employees and if they stayed with the company until retirement, they would enjoy the peace of mind and security provided under the Security Program, including paid up medical insurance. At the time the promises were made, both parties had relatively equal bargaining power. The corporation offered a set of benefits, including both present and deferred compensation, and the employee offered the promise of quality service in return. As an employee rendered services, he earned present salary and commissions, as well as deferred compensation in the form of pension and welfare benefits. Retirement following years of service culminates in the discharge of the employee's duty under the contract, having fully performed his end of the agreement. Upon retirement the bilateral bargaining position of the parties ceased. The employee was now entitled to receive those earned benefits deferred until retirement. Deferred retirement benefits earned during active employement are enforceable contract rights. In *Hoefel v. Atlas Tack Corp.*, 581 F.2d 1, 4 (1st Cir. 1978), *cert. denied*, 440 U.S. 913, 99 S.Ct. 1227, 59 L.Ed.2d 462 (1979), the court cites authorities in more than ten jurisdictions for the proposition that "a unilateral offer of deferred earnings becomes irrevocable upon an employee's rendering of many years of faithful service and reaching retirement." *Id.* at 4-5, (quoting *Rochester Corp. v. Rochester*, 450 F.2d 118, 120-21 (4th Cir. 1971)).

> Even though the employer has reserved the right to amend or terminate the plan, once an employee, who accepted

> employment under such a plan, has complied with all the conditions entitling him to participate in such a plan, his rights become vested and the employer cannot divest the employee of his rights thereunder.

Hoefel, at 5-6. This reasoning also was followed in *In re Erie Lackawanna Railway Company*, 548 F.2d 621, 625-27 (6th Cir. 1977), in which the court prohibited the enforcement of a termination clause contained in a life insurance plan, reasoning that operation of the clause would work a forfeiture without good and sufficient cause.

> [U]nder our economic system, an employer cannot offer a retirement system as an inducement to employment and, after an employee has accepted employment under such conditions, withdraw or terminate the program after an employee has complied with all the conditions entitling him to retirement rights thereunder.

Id. at 627. The termination clause in *Erie Lackawanna* provided: "The Company reserves the right to terminate the plan." Notwithstanding the unqualified provision, the court refused to give it effect — first looking to contract law to find an implied term requiring each party to discharge their duty to perform in good faith, and then looking to equity for the proposition that equity abhors a forfeiture. *Id.* at 627.

> This principle is particularly well settled in the law of insurance; and of course it must also be remembered that it is one of the best-known principles of insurance law that a policy or contract of insurance is to be construed liberally in favor of the insured or his beneficiary, and strictly construed against the insurer.

Id. at 627. (citations omitted). There must be some form of mutuality of obligation and exchange of consideration to warrant amendment of retirement benefits. Without a showing of "good and sufficient cause," an employer may not unilaterally make such an amendment. *Id.*

The termination/modification clause in this case is not unenforceable and void as a matter of public policy. Rather, American General may not seek its operation unless, as the provision is worded in the summary plan descriptions, such a change is "necessary." The Court interprets the requirement of necessity to demand a good faith, sufficiently compelling financial reason to amend the level of benefits promised over the period of employment and on which employees have justifiably relied. "It would be unjust and inequitable, following this justifiable reliance . . . to permit any tampering, statutorily or otherwise, with their pension benefits." *Miles v. Tennessee Consolidated Retirement System*, 548 S.W.2d 299, 305 (Tenn. 1976) (invaliding Tennessee statute modifying the pension plan of the Tennessee judiciary). In *Miles*, the Supreme Court of Tennessee stated that the legislature could not statutorily amend the provisions of the judicial pension plan absent "a vital interest of the state." *Id.* at 305. Similarly, in this case, American General must demonstrate, not that the costs of the medical insurance plan far outweigh the insurance premiums paid by retirees, but rather that the contractual promises previously made are now avoidable because of some unforeseen contingency that threatens the financial base of the entire corporation. In light of American General's earnings during the first half of this year, the Court does not view the alleged incremental cost attributable to the retirees' medical insurance plan to constitute sufficient cause to warrant amendment of the plan.

Finally, ERISA expressly requires that termination procedures be set forth in the plan documents. 29 U.S.C. § 1102(b). The purpose of this requirement is to inform beneficiaries and participants of the process by which their level of benefits may be affected and, also, to hold trustees to strict standards of fiduciary responsibility in implementing such amendments. In this case, both NLT and American General's summary plan descriptions contain no procedures concerning termination. The procedural violation does not render the particular clauses unenforceable, rather, this Court will require a

howing of at least good faith and cause prior to their invoca-ion.

The defendants argue that for this Court to hold for the laintiffs will result in a chilling effect on employers' likelihood f offering welfare benefit plans. The Court believes, however, hat an employer must take a more realistic approach to the pro-ises he makes in seeking to solicit and retain quality employees nd not to promise more than he is willing to pay.

) *American General's Role as Fiduciary For the Retiree Benefit Plan.*

(1) *American General's Fiduciary Duties*

American General's role as a fiduciary of the retiree benefit plans is distinct from its role as the successor to the retiree's former employer, National Life and NLT. Under Part 4 of ERISA, 29 U.S.C. § 1101-14, standards of fiduciary conduct are imposed upon the administrator of employee benefit plans. Unlike the common law prohibition against dual loyalties, Congress permits the fiduciary of benefit plans to assume multiple obligations. *Donovan v. Bierwirth*, 538 F.Supp. 463, 468 (E.D.N.Y. 1981), *modified on other grounds*, 680 F.2d 263 (2d Cir.), *cert. denied*, 459 U.S. 1069, 103 S.Ct. 488, 74 L.Ed.2d 631 (1982) (holding that the use of fund assets to fend off a hostile tender offer, since made without sufficient inquiry into the facts, constitutes a violation of the fiduciary standards under ERISA).

Recognizing the potential conflicts of interest that might arise hen a corporation serves both as the employer and the duciary, Congress has carefully delineated the fiduciary duties pon the corporation as fiduciary of employee benefit plans.

> . . . [A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and —

(A) for the exclusive purpose of:

(i) providing benefits to participants and beneficiaries; and

(ii) deferring reasonable expenses of administering the plan;

(B) With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) By diversifying the investments of the plan so as to minimize the risks of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) In accordance with documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

S.C.A. § 1104 (1984 Supp.). Assets of an employee t plan generally are required to be held in trust for the t of plan participants and/or beneficiaries. 29 U.S.C. § a). However, as is the situation in this particular case, which consist of insurance contracts or policies, or which tute the assets of an insurance company are expressly ex- l from the requirements that such assets be held in trust. S.C. § 1103(b). However, regardless of whether assets are n trust, a fiduciary is charged with strict standards of care administration and management of plan assets. The ary must manage those assets solely in the interest of plan ipants and beneficiaries.

ing the presentation of evidence in this case, defendants Mr. Donald S. Grubbs, Jr., as a witness. (*See* Exhibit 45 rt Witness Statement)). Mr. Grubbs is a leading authority

ERISA. During congressional investigation leading up to the ctment of ERISA, Mr. Grubbs was commissioned by the ate Subcommittee on Labor to prepare a report on the costs nandatory vesting provisions. A summary of the report ap- rs in an appendix to the report of the Senate Committee on bor and Public Welfare. S.Rep. No. 93-127, 93rd Cong., 2d s., *reprinted in* 1974 U.S.Code Cong. & Ad.News 4838, 4-4889. During Mr. Grubbs' testimony, the witness stated t the fiduciary standards expressed under ERISA are not ap- able to the administrator of a welfare benefit plan to the ex- t that there are no assets expressly set aside to fund the par- lar plan. That is, to the extent that a corporation merely ds general assets to pay for a particular plan — in this case medical insurance benefits — no fiduciary standards of care ulate the administrator's conduct. The Senate Report to ch Mr. Grubbs' report is an appendix states:

> The fiduciary responsibility section, in essence, codifies and makes applicable to these fiduciaries certain principles developed in the evolution of the law of trusts.
>
> * * * * * *
>
> Section 15(a) when read in connection with the definition of the term "employee benefit fund" makes it clear that the fiduciary provisions apply only to those funds which leave assets at risk. While the Retirement Income Security for Employees Act has the effect of requiring all retirement plans subject to that Act to be financed through the medium of a segregated fund, there may be welfare funds subject to the Welfare and Pension Plans Disclosure Act such as those providing sickness or disability benefits, which may not be funded. Thus, an unfunded plan in which the only assets from which benefits are paid are the general assets of the employer is not covered.

at 4865-4866.

ıtiffs introduced into evidence copies of the medical in-
: plans provided under the NLT/NLA Security Program.
g., Exhibit 5, 37, 38). The Court views the master policy
by NLT/NLA, as the insurance carrier of such plans, to
by American General in its fiduciary capacity as the ad-
ator of the welfare benefit plan for the retirees. Stated
way, NLT/NLA, as the employer, promised a certain
medical insurance benefits. Pursuant to the promise,
ployer made arrangements to purchase from itself in-
policies to carry out its promise. Once purchased, the
policies were held by NLT/NLA (and now by American
l) as an administrator of the welfare benefit plans. Under
's fiduciary standards, American General holds and
dminister the insurance policies solely in the interest of
rees.

A trust is not to be required in the case of plan assets
ich consist of insurance (including annuity) contracts or
licies issued by an insurance company qualified to do
siness in a State (or the District of Columbia) . . . .
though these contracts need not be held in trust, [29
S.C. § 1103(b)], nevertheless the person who holds the
ntract is to be a fiduciary and is to act in accordance with
fiduciary rules of the substitute [bill] with respect to
se contracts. For example, this person is to prudently
e and keep exclusive control of the contracts, and is to
prudent care and skill to preserve this property.

To the extent that plan assets are held by an insurance
mpany they need not be held in trust. However, to the
ent the substitute [bill] treats assets held by an insurance
mpany as "plan assets", the insurance company is to be
ated as a fiduciary with respect to the plan, and is to
et the fiduciary standards of the conference substitute.

nf.Rep. No. 93-1280, 93rd Cong., 2d Sess., *reprinted in*
S.Code Cong. & Ad.News 5038, 5079. Plaintiffs in-

troduced NLA's 1983 Form 5500 filed with the IRS reporting the annual return on the group medical, life, and AD & D policy. Schedule A, Item 9(d) reports $42,263,925 as policyholder reserves held to provide benefits after retirement. At this point in the proceeding, it is not clear whether this amount constitutes a dedicated asset to fund the medical insurance plan or merely represents a line item for tax purposes only, constituting a nondedicated portion of the corporation's general assets. In light of the statutory provisions and legislative history discussed above, to the extent the amount represents a dedicated asset, American General, as the administrator of the medical insurance plan would be subject to the fiduciary provisions under ERISA. While ERISA does not require mandatory funding of welfare benefit plans, 29 U.S.C. § 1081(a)(1), ERISA does not prohibit an employer from funding such a plan. Whether NLT/NLA opted to fund its medical insurance plan presents a question of fact for adjudication.

Regardless of the resolution of this particular issue, the Court finds that the plaintiffs have a substantial likelihood of success on the proposition that American General was subject to a fiduciary duty with respect to holding and protecting the issued insurance policy covering the medical insurance plan.

(2) *American General Had a Duty to Assure the Continuation of Funding Required Under the Employment Contract Between Plaintiff Retirees and NLT/NLA.*

The Court has discussed the federal common law contractual principles on which the retiree's may proceed under ERISA in seeking to procure American General's continued fundingof the medical insurance plans. As the fiduciary of the plan, American General has a duty to insist that the plan be funded "in accordance with the documents and instruments governing the plan." 29 U.S.C. § 1104(a)(1)(D). The plaintiffs have demonstrated that the documents and instruments require American General

as "employer" to continue to fund paid up benefits at pre-January 1, 1984, levels; American General, as fiduciary, has the statutory obligation to assure that American General, as employer, discharges that funding obligation.[12]

(3) *The Incorporation of an Escape Clause Providing for the Termination of Medical Insurance Should a Retiree be Covered by Another Employer's Insurance Constitutes Arbitrary and Capricious Conduct.*

Courts extend great deference to the administrator of a welfare benefit plan and will not vacate an administrator's decision unless such action is shown to be arbitrary and capricious, or made in bad faith. *Jung v. FMC Corp.*, 755 F.2d 708 (9th Cir.1985). American General's regulation requiring the termination of a retiree's medical insurance in the event that he is covered by another employer's medical insurance policy constitutes arbitrary and capricious conduct in violation of the fiduciary standards imposed under ERISA. In *Northeast Department ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund;* 764 F.2d 147 (3d Cir.1985), the court concluded that an escape clause requiring automatic forfeiture of medical insurance was unenforceable by virtue of ERISA's fiduciary standards, because the provision took into account no consideration of the relative comparability of the other insurance coverage. In *ILGWU,* a union employee had retained benefit rights under two medical insurance plans.

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[12] Finally, to the extent that plaintiffs can demonstrate at a full trial on the merits that the $42,000,000 appearing on the Form 5500 constitutes a dedicated asset to the medical insurance benefit fund, another issue exists as to the present status of that fund and whether it continues to remain at its prior level. Under ERISA, "the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries in defraying reasonable expenses of administering the plan." 29 U.S.C. § 1103(c)(1). This issue was not sufficiently examined at the hearing on the preliminary injunction.

Following an operation, the employee made a claim with one multiemployer plan who denied coverage because of her coverage under another plan. The employee then sought reimbursement from the other plan which also had an escape clause and denied coverage. The employee filed suit. The district court found in favor of the employee and ordered an award, retaining jurisdiction over the two plans to determine contribution. In declaring the escape clauses void per se, the court observed

> [O]ne very important policy underlying ERISA is that employees enrolled in a benefit plan should not be deprived of compensation that they reasonably anticipate under the plan's purported coverage. Escape clauses, however, risk just such a result. An escape clause ... does not contain any requirement that the coverage provided by the other plan be comparable to the coverage provided in the escaping plan before the latter plan will defer liability. In addition, unlike plans with excess clauses, a plan with an escape clause does not provide participants who receive less in benefits from the other plan with the opportunity to return to the first plan for the difference. As a result, a participant of a plan with an escape clause, who thinks that he is covered by that plan and who expects to recover medical expenses in accordance with the terms of that plan, automatically loses this coverage in the presence of another insurance plan, even if the benefits he is entitled to receive under the other plan are much less favorable than those of his own. In our view, trustees who incorporate in a plan a provision that has the potential to harm participants in this way have indeed acted in an arbitrary and capricious manner. Accordingly, we hold that the escape clauses in ERISA covered employee benefit plans are unenforceable as a matter of law.

Id. at 163-64. As administrator of the medical insurance plan, American General has the duty to act solely in the interests of

the retiree beneficiaries. At the hearing, defendants put on no evidence to demonstrate the benefit to be gained by the retirees through enforcement of such a provision. The Court cannot determine that any exists. The clause discourages a retiree from seeking alternate employment because of the threat of losing one's medical insurance permanently, regardless of the level of other insurance or the duration of the other employment opportunity. The escape clause is anticompetitive, and constitutes a breach of American General's fiduciary duty; it is unenforceable as a matter of law.

(4) *The Requirement of Immediate Election for Spousal Survivor Benefits Constitutes Arbitrary and Capricious Conduct.*

Unlike medical insurance benefits, spousal survivor benefits constitute a form of pension benefit and are therefore covered by the comprehensive vesting and participation provisions and the funding provisions under ERISA. 29 U.S.C. § 1055. The plaintiffs in this case may accrue vested rights to such benefits. Under the terms of the Security Program, retirees who left active employment with NLT/NLA prior to age 65 were given a window period during they could decide whether to elect to enter the spousal survivor program. The election was not required to be made until age 65. Those retirees opting for the survivor benefits were required to commence contributions, which were deducted from the monthly annuity to which the retiree was entitled. As of July 1, 1984, all NLT/NLA employees who had continued on with American General following the merger, but who had retired after January 1, 1984, were required to immediately elect to join the spousal survivor benefit program and make contributions. Under the NLT/NLA Security Program, these retirees could have waited until age 65 to take the option and to avoid contributions until that time. American General ended the practice. At the hearing, American General made no response to what the plaintiffs termed arbitrary and capricious conduct. Like the escape clause

to the medical insurance benefits, this Court can conceive of no basis on which the elimination of the window period for election constitutes action made solely in the interest of the beneficiary. Although the elimination would seem to have the prospect of generating additional revenues for American General, the elimination does not appear to benefit the beneficiaries. Hence, the elimination constitutes arbitrary and capricious conduct in violation of American General's fiduciary duties.

2. *Plaintiffs have Demonstrated the Prospects of Irreparable Harm.*

The second finding this district court must make prior to the issuance of a preliminary injunction is the finding that the plaintiffs have demonstrated the likelihood of irreparable harm absent a preliminary injunction. *Friendship Materials, Inc. v. Michigan Brick, Inc.*, 679 F.2d 100 (6th Cir.1982); *Advisory Information & Management Systems, Inc. v. Prime Computer, Inc.*, 598 F.Supp. 76 (M.D.Tenn. 1984). The plaintiffs in this case are retirees, most of whom are on fixed incomes. The prospect of doubling the present medical insurance premiums—and going from no premium prior to January 1, 1984—threatens the class both with monetary hardship and emotional anguish.

Ordinarily, to the extent an alleged harm is redressable by a retroactive award of monetary damages, there is little prospect of irreparable harm. In this case, however, the Court is faced with an unusual class of plaintiffs. Defendants stated that of a class of approximately 2,500 persons, four to five individuals die each month. Assuming this case follows the normal course of appeals (and possible remands) seen in many complex cases, a final resolution of this case may not be achieved for three to four years. Ten percent of the class may have died during this period. Assuming the plaintiffs prevail, the retroactive award of monetary damages to these decedents' estates would not be sufficient to compensate the individuals for their loss.

More importantly, the Court is sensitive to the mental anguish suffered by many members of the class faced with the

prospective increase in their medical insurance premiums. As individuals who have dedicated their life service to their employer, it is understandable that many would be frustrated by a reduction in the benefits they had been promised during their active employment years. Although American General characterizes the economic hardship on these individuals as merely $30.00 per month, the increase in premiums imposes an opportunity cost requiring the beneficiaries to forego other activities, perhaps necessities, which they would spend their monies on during their retirement years. Moreover, the retirees lose the intangible, yet very real sense of security that accompanies the knowledge that one has a reliable source of income to count on. If American General can modify the plan at will, the retirees have no assurance as to the future level of benefits, the premiums, or the deductible they must meet.

The enforcement of the "other income" escape clause imposes irreparable harm. If the insurance offered by the other employer ceased for some reason, the American General insurance would not be reinstated, leaving the plaintiff without any medical insurance whatsoever. This Court concurs in the holding of the district court in *UAW Local 107 v. White Farm Equipment Co.*, 5 Employees Benefit Cases [BNA] 2449, 2453 (D.Minn. Oct. 19, 1984).

> The loss of health insurance benefits and the possibility that retirees will be forced to pay for insurance coverage with dollars previously committed to some other necessity of life satisfies the movants' burden to establish a threat of irreparable harm.

The Court is satisfied that the plaintiffs have made such a showing in this case.

3. *Issuance of a Preliminary Injunction Serves the Public Interest.*

The principal policy objective of ERISA is to secure employee's retirement income. In this way, individuals can rely

on private sources of financial support during their retirement years and, therefore, will not have to rely on public subsidy. The reduction of reasonably anticipated levels of retirement benefits threatens to make those who have carefully planned for their retirement reliant on other sources of income. As between public financing and financing by American General, in light of the Court's discussion of the plaintiffs' likelihood of success on the merits, the Court concludes that American General should be required to continue to honor the promises made by NLA/NLT to finance the medical insurance plan.

The escape clause for other insurance is anticompetitive in the sense that it discourages a retiree from seeking other employment after he retires. The escape clause may be compared to a covenant not to compete, which generally are void as against public policy unless shown to serve a rational purpose limited in time and space. *See Koehler v. Cummings,* 380 F.Supp. 1294, 1308 (M.D.Tenn.1971).

Finally, the United States, like other civilized societies, has a paramount interest in protecting the health and welfare of its elderly. While recognizing that a genuine issue exists, the Court nevertheless determines that as between the retirees and American General, the public interest lies with the retirees in protecting their limited income from the possibly arbitrary and capricious diminution by the proposed changes of American General.

4. *Harm to Others.*

The issuance of the preliminary injunction, if improvidently granted, threatens only temporary monetary losses to American General. Having earned record profits during the first half of 1985, the incremental monetary costs placed upon American General will not threaten its financial solvency. While defendants argue that the issuance of a preliminary injunction will make other employers in the private sector reluctant to offer medical insurance to their employees following retirement, this

Court finds that effect of the injunction may make employers more careful about the representations they make concerning post-employment benefits and more likely to carefully assess the financial commitment they are willing to make concerning such benefit plans.

5. *Security*

The Court has the authority to require the plaintiffs to post adequate security prior to the issuance of this preliminary injunction. Fed.R.Civ.P. 65. Upon this Court's issuance of a temporary restraining order, American General waived its right to security. Because the Court is uncertain as to American General's position on security regarding a preliminary injunction, the Court will reserve the question of security and will permit the defendant ten days from the receipt of this order to respond to plaintiffs' request that security not be ordered in this matter.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE,
NASHVILLE DIVISION

Civil Action No. 3-85-0546

Judge Wiseman

Robert L. Musto, A. M. Tenison, Jr., Mildred Chandler, Clyde Bell, Thomas Gates, Luther Cowherd, Charles McCharen and H. L. Cagle, on behalf of themselves and as representatives of a class of persons similarly situated,

Plaintiffs,

v.

American General Corporation, The Restated American General Retirement Plan, The American General Early Retiree Medical Plan, The American General Normal Retiree Medical Plan, The American General Personnel Administration Committee, Andrew Delaney, Harold Hook, Darrell Olges, John Doe and Jane Doe,

Defendants.

MEMORANDUM

(Filed Nov. 5, 1985)

Defendants have filed a motion for direction and clarification of class which raises several issues regarding this Court's Order dated August 23, 1985. In that Order, the Court certified the plaintiff class and preliminarily enjoined defendants from enforcing various changes involving plaintiffs' retirement benefits.

I. *Clarification of Class Definition*

A. *Inclusion of Active Employees in Subclass B*

In this Court's previous Order, Subclass B was defined as follows:

> Subclass B consists of all those retirees who retired or were qualified but had not yet retired after January 1, 1984, but before July 1, 1984.

Order dated August 23, 1985, at 17-18.

Defendants point out that Subclass B as defined may be construed to include all individuals who were eligible to retire between January 1, 1984 and July 1, 1984, but who continue to be employed with the company. The Court did not intend for these employees to be included in the class. Accordingly, in order to clarify the definition of Subclass B, this Court's previous Order will be amended to provide:

> Subclass B consists of all those retirees who, after December 30, 1983 but before July 1, 1984, had either (i) retired, or (ii) qualified for and requested retirement.

B. *Inclusion of Surviving Spouses in the Class*

Defendants also point out that the Court's definition of the class in its previous Order is silent on the question of whether surviving spouses of deceased relatives are included. They contend that surviving spouses of deceased relatives should not be included because, they argue, their claims are not typical, no evidence of the numerosity of these individuals has been presented, and no named plaintiff adequately represents these individuals.

Inclusion of surviving spouses in the plaintiff class was implied, if not explicit, in this Court's previous Order. That Order outlined the various benefits offered under the NLT/NLA and American General medical plans to surviving spouses, as well as to retirees. In addition, the Court measured the numerosity of the class with surviving spouses included. Moreover, the Court notes that the case upon which this Court principally relied in its

previous Order, *In re White Farm Equipment Co.*, 42 B.R. 1005 (Bankr. N.D. Ohio 1984), involved a plaintiff class consisting of retirees and surviving spouses of deceased retirees.

With repect to defendants' objections, the Court specifically finds that sufficient evidence was presented at the class certification/preliminary injunction hearing to establish that surviving spouses are beneficiaries under both the NLT/NLA and American General medical plans. As such, the Court finds their claims to be typical of the claims asserted by the named plaintiffs, and to involve common questions of law and fact. Furthermore, the Court believes that the named plaintiffs will adequately represent surviving spouses because in asserting the claims of surviving spouses, they will essentially be asserting their own claims, and will be protecting their own spouse's interest.

The difference in the terms of the NLT/NLA and American General medical plans as they apply to surviving spouses requires the Court to identify the group of surviving spouses to be included in Subclass A. Surviving spouses of employees who retired before January 1, 1984 were covered under the NLT/NLA plan until that plan was changed on July 1, 1984. Under the NLT/NLA plan, surviving spouses received coverage beyond age 65 only if the deceased retiree had accumulated twenty-five or more years of service with the company when he/she retired. Under the American General plans which applied to employees who retired after January 1, 1984, surviving spouses receive continuing coverage regardless of the retiree's accumulated years of service. Thus, Subclass A will include only surviving spouses of pre-January 1, 1984 retirees who are entitled to receive coverage under the NLT/NLA plan because their spouse rendered the required number of years of service. Accordingly, this Court's previous Order defining the class will be amended to provide:

> Subclass A consists of all those retirees who left active employment prior to January 1, 1984, and the surviving

spouses of deceased retirees (retiring prior to January 1, 1984) who were covered under the NLT/NLA plan on June 30, 1984. Subclass B consists of all those retirees who, after December 30, 1983 but before July 1, 1984, had either (i) retired, or (ii) qualified for and requested retirement, and the surviving spouses of any such retirees.

II. *Direction for Implementation of Preliminary Injunction*

A. *Spousal Survivor Benefits*

By Order dated August 23, 1985, this Court preliminarily enjoined defendants from "enforcing the May 1984 modification of spousal survivor benefits offered under the NLT/NLA plan." In their motion, defendants have divided the class members into various groups and seek direction as to how the Order is to apply to each of them. As was explained in this Court's previous Order, American General's May 1984 modification of the NLT/NLA pension plan requiring retirees to make an election of spousal survivor benefits at retirement instead of permitting deferral of that election until age 65 as required under the NLT/NLA plan constitutes arbitrary and capricious conduct in violation of American General's fiduciary duties. The May 1984 modification required all retirees to immediately elect spousal survivor benefits from a list of options specified in the American General Pension Plan ("AG Options") instead of from the list of options specified in the NLT/NLA pension plan ("NLT Options"). The AG Options went into effect on January 1, 1984. The intent of this Court's previous Order was to enjoin defendants from requiring elections to be made before a retiree reached age 65 and implied, if not explicit, in that Order was the requirement that American General allow these retirees to make their elections from the list of options contained in the pension plan in effect at their retirement. Although the Court believes that this statement resolves the spousal survivor benefit issues raised in defendants' motion, for clarity's sake, the Court will address each group separately.

1. *Persons retiring before January 1, 1984, who have not yet reached age 65, and who elected survivor benefits from AG Options.*

This Court's Order requires that these retirees be allowed to wait until age 65 to elect spousal survivor benefits. The election will be made based upon the NLT/NLA Options.

2. *Persons retiring before January 1, 1984, who attained age 65 after January 1, 1984, and who have elected survivor benefits from AG Options.*

These retirees are required to make a new election based on NLT/NLA Options. The Court recognizes that some members of this group who have elected the AG joint and 100 percent option may not qualify for the joint and 100 percent option offered under the NLT/NLA plan. Those class members may choose to opt-out of the class if they are dissatisfied with the NLT/NLA Options.

3. *Persons retiring between January 1, 1984 and July 1, 1984, who have not yet reached age 65, and who have elected survivor benefits from AG Options.*

Members of this group will be permitted to defer election until age 65, at which time they will be required to make their election based upon AG Options.

4. *Persons retiring between January 1, 1984 and July 1, 1984, who reached age 65 prior to the Court's Order, and who have elected survivor benefits from AG Options.*

Nothing more is required of these retirees.

B. *Sex Neutral Reduction Factors.*

Defendants indicate that application of the NLT/NLA reduction factors may run afoul of the Supreme Court decision in *Arizona Commission for Deferred Compensation Plans v. Norris,* 463 U.S. 1073, 103 S.Ct. 3492, 77 L.Ed.2d 1236 (1983),

which prohibits the use of sex based actuarial reduction factors. Compliance with the Supreme Court's decision would have been required had the NLT/NLA pension plan remained in existence. Therefore, defendants will be permitted to modify the NLT/NLA reduction factors to the extent required by the Supreme Court's decision in *Norris*. Defendants will be required to submit a copy of these modifications to plaintiffs' counsel.

C. *Notification of Reinstatement*

Defendants have also requested clarification on whether they are required to offer those individuals who did not enroll in the American General Early Retirement Medical Program effective July 1, 1984 another opportunity to enroll in that program. This issue is also the subject of a motion for enforcement of preliminary injunction submitted by plaintiffs, in which they request the Court to order defendants to immediately notify all class members that they are no longer subject to the "escape clause."

In the August 23, 1985 Order, the Court found that inclusion of an escape clause in defendants' medical insurance plan constitutes arbitrary and capricious conduct, and enjoined enforcement of that clause. The Court also required the defendants to reinstate those retirees who had been terminated based on that clause. In resolving both the motion for clarification and direction submitted by defendants and the motion for enforcement of the preliminary injunction submitted by plaintiffs, the Court requires that defendants permit all class members to re-enroll in the plan. The class members should be notified of the opportunity to re-enroll by including this information in the notice of the class action.

D. *Reinstatement and ERISA*

Finally, defendants contend that reinstatement of the NLT/NLA retirement plan may violate various provisions of

the Employee Retirement Income Security Act of 1974 ("ERISA") and the Internal Revenue Code of 1954. The Court does not believe that defendants' contention requires a response at this time.

/s/ Thomas A. Wiseman, Jr.
Chief Judge

APPENDIX D

Subtitle A—General Provisions

§ 1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to

adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

APPENDIX E

§ 1102. Establishment of plan

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

Supreme Court, U.S.
FILED
MAR 15 1989
JOSEPH F. SPANIOL, JR.
CLERK

No. 88-1376

IN THE

Supreme Court of the United States

October Term, 1988

ROBERT L. MUSTO, *et al.*,

Petitioners,

vs.

AMERICAN GENERAL CORPORATION, *et al.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the United States Court of Appeals for the Sixth Circuit ("Court of Appeals") erred in holding that the terms of the written employee welfare benefit plan sponsored by Respondents will be the primary determinant of Petitioners' benefits under the plan.

2. Whether the Court of Appeals committed reversible error by applying a uniform body of federal common law developed under the Employee Retirement Income Security Act of 1974 ("ERISA"), rather than state insurance law, to interpret the terms of the employee welfare benefit plan sponsored by Respondents.

STATEMENT OF CORPORATE AFFILIATES PURSUANT TO SUPREME COURT RULE 28.1

See Appendix.

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STATEMENT OF THE CASE

In 1945, the National Life and Accident Insurance Company ("NLA") established a medical benefits program for its employees (Ptnr. Apx. A, A-1).[1] The medical benefits program provided employees with reimbursement for specific types of medical expenses up to specified dollar amounts. Subject to a maximum lifetime benefit of $500 for all medical expenses, the program provided medical expense reimbursement to retirees.

During the next 40 years, the program was amended several times (Ptnr. Apx. A, A-2). Sometimes employees and retirees were required to make contributions in order to receive coverage under the program and sometimes they were not.[2] Id. The numerous changes in the coverage provided to both active employees and retirees were made pursuant to an expressly reserved right to modify or terminate the program in NLA's sole discretion.[3] (Ptnr. Apx. A, A-2). This express reservation appeared in the master plan documents and in the numerous booklets and certificates distributed to Petitioners over the years. (Ptnr. Apx. A, A-2, A-7, A-8, A-10, A-11, A-13, A-14,

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[1] References herein to "Ptnr. Apx." are to the Appendix filed with the *Petition for a Writ of Certiorari* and are followed by the page number of the cited text.

[2] Petitioners, in the first of several incorrect "factual" statements appearing in their Statement of the Case, allege that the "company paid for it [the medical coverage]." *Petition for a Writ of Certiorari*, (hereinafter "Petition") p. 3. In fact, the record clearly shows that contributions were required of both active employees and retirees from time to time. Because Petitioners do not ask the Court to review the factual findings of the Court of Appeals, they are not free to ignore them in their Statement of the Case.

[3] Petitioners allege as fact that "Respondents never claimed the right to reduce the benefits of employees who had already retired." (Petition p. 3). Once again, Petitioners ignore the record. The Court of Appeals found just the opposite (Ptnr. Apx. A, A-2, A-6, A-7, A-8). Even the District Court, which held in Petitioners' favor, found that, "[t]he termination/modification clause contained in the NLT/NLA summary plan descriptions, clearly and expressly reserve (sic) the right to amend or terminate the medical insurance benefit plan." (Ptnr. Apx. B, A-62).

A-16, A-17). The changes generally resulted in benefit improvements and, by 1984, a Petitioner who retired under the 1945 program had seen the ceiling on his post-retirement coverage increased from $500 to $100,000.[4]

In 1982, Respondent American General Corporation acquired NLA and in 1984, NLA's employee benefit programs were modified to conform to the programs provided by American General Corporation to its employees and employees of its other subsidiaries. (Ptnr. Apx. A, A-2). The changes included reductions (for example, required contributions) and improvements (for example, a doubling of the ceiling on post-retirement coverage to $200,000).[5]

Claiming that Respondents could only change their post-retirement medical coverage for the better, and that all the prior improvements in coverage made after their retirement were vested, Petitioners sued in the United States District Court for the Middle District of Tennessee ("District Court") to enjoin the 1984 changes.[6] The District Court, relying on the

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[4] At the commencement of this action, there was a small number of Petitioners who retired under the 1945 plan. Many more retired when maximum limits of $5,000, $10,000, and $25,000 were in effect.

[5] In an apparent attempt to obtain the Court's sympathy, Petitioners distort the record by arguing that "Respondents terminated the medical insurance for retirees who were unable to pay the required premium contributions. For many retirees, the contributions were more than the pension they received." (Petition p. 3.) This allegation finds no support in the record. The two witnesses Petitioners presented who did not elect coverage both testified that they elected not to enroll because they had better coverage elsewhere. The District Court found that "it could not determine how many [Petitioners] chose not to enroll because the cost was prohibitive." (Ptnr. Apx. B, A-46).

[6] As the Court of Appeals noted, "[r]egardless of when they had retired, the Plaintiffs sought to freeze their medical insurance coverage at the configuration that applied to them on June 30, 1984." (Ptnr. Apx. A, A-3). Approximately 70% of the Petitioners retired before the plan they seek to reinstate became effective. These Petitioners want to benefit from the pre-1984 modifications to their retiree medical coverage (which they liked) and

state law doctrine of unilateral contract espoused in *In re White Farm Equipment Co.*, 42 Bankr. 1005 (N.D. Ohio 1984), *rev'd*, 788 F.2d 1186 (6th Cir. 1986), found that the modification/termination clause in the plan documents was unenforceable unless plan modification was necessary to prevent insolvency. (Ptnr. Apx. B, A-65). Based upon this holding, the District Court issued a preliminary injunction restraining Respondents from making any further changes in the post-retirement medical program. (Ptnr. Apx., A, A-34).

Respondents appealed and, on November 15, 1989 "after a careful search of the record," the Court of Appeals reversed the District Court, finding that Petitioners had failed to establish the requisite probability of success on the merits of their claims.[7] (Ptnr. Apx. A, p. A-33). Specifically, the Court of Appeals found that Respondents had clearly and consistently reserved the right to modify the post-retirement coverage in

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claim the modification clause is not enforceable for the 1984 changes (which they did not like).

[7] In yet another mischaracterization of the Court of Appeals' decision, Petitioners allege, "The Sixth Circuit determined that as a matter of law .... [b]ecause ERISA does not require vesting of welfare plans, an employer may change or terminate those plans at any time for any reason no matter what the reasonable expectations of the Retirees" (Petition, p. 4). On the contrary, the Court of Appeals devoted no less than 15 pages of its opinion (Ptnr. Apx. A, A-9 through A-23) to an exhaustive analysis of the Petitioners' reasonable expectations based on information given to Petitioners concerning their coverage. The Court of Appeals concluded:

> Nowhere in that or any other employee publication — or in any memorandum, letter, brochure, report, or other written document, as far as we have been able to ascertain after a careful search of the record — did the company ever promise any employee that all premiums for post-retirement medical coverage would be irrevocably "paid up" upon the employee's retirement. (Ptnr. Apx. A, A-21).
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> Nowhere in the district court's opinion is there a specific finding that any National Life employee received an oral promise that his post-retirement medical insurance coverage would be permanently, irrevocably, and fully "paid up." (Ptnr. Apx. A, A-23).

the master plan documents (insurance policies) and in the many written communications issued to Petitioners describing the program. (Ptnr. Apx. A, A-2, A-7, A-8, A-10, A-11, A-12, A-13, A-16, A-17, A-19, A-21, A-23). Moreover, the Petitioners' coverage had been modified several times in the past by Respondents without objection in accordance with this reserved right. (Ptnr. Apx. A, A-2).

SUMMARY OF ARGUMENT

Petitioners ask this Court to review the Court of Appeals' decision for the purpose of considering adoption of a common law vesting rule which would prevent the sponsor of a retiree medical benefit plan from ever changing the coverage provided to any retiree regardless of whether the plan's written terms permit changes and regardless of whether the plan has been changed in the past in accordance with its terms.[8] Petitioners also urge the Court to grant *certiorari* and find that the Court of Appeals erred by failing to apply a "doctrine of reasonable expectations" alleged to exist under state insurance law in interpreting the documents governing the retiree medical benefit plan. (Petition p. 11).

The Petition should be denied because it raises none of the considerations governing review on *certiorari*. U.S. Sup. Ct. R. 17.

With respect to Petitioners' advocated common law vesting rule, the decisions of the United States Courts of Appeals are in complete accord. Every circuit that has been asked to adopt the rule has rejected it.[9] Similarly, there is no important question of federal law to be settled by this Court because the basic premise of Plaintiffs' argument — that the Court of Appeals' construction of ERISA destroys preexisting em-

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[8] Although Petitioners disguise their common law vesting rule as the "doctrine of unilateral contract" (Petition, p. 6), it is nothing more than a mandatory vesting rule for retiree medical plans.

[9] No conflict with a state court of last resort or with the prior decisions of this Court is alleged and none exists. U.S. Sup. Ct. R. 17.1.

ployee rights — is false. There was no pre-ERISA common law or statutory rule applicable to Petitioners or the public generally which prohibited modification of a post-retirement medical program. Even if there was, Congress answered the question Petitioners now submit to this Court by explicitly excepting medical benefit plans from the plans subject to ERISA's vesting requirements and by broadly preempting the state law upon which Petitioners base their arguments.

With respect to Petitioners' assertion that the Court of Appeals' decision conflicts with other circuits because it did not apply insurance law in interpreting the plan, this argument is made for the first time in the Petition and is simply a plea for this Court to reconsider the factual findings of the Court of Appeals.[10] There is no conflict among the circuits over the application of state insurance law to interpret medical benefits plans under ERISA. Morecover, the Court of Appeals' extensive factual findings, which are not reviewable absent gross error, conclusively establish that Petitioners could never have *reasonably* expected what they now demand.

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[10] Petitioners argued below that the federal common law would control their entitlement to benefits. They have never before argued that state insurance law should apply in construing the terms of the plan documents. The District Court held that all Petitioners' state law claims (which did not include insurance law claims) were preempted. (Ptnr. Apx., A, A-53). This holding was not disputed by Petitioners on appeal. Having lost under the federal common law they advocated, Petitioners now ask this Court to give them an opportunity to prove their case under state insurance law.

"Ordinarily, this Court does not decide questions not raised or involved in the lower court." *Youakim v. Miller*, 45 U.S. 231, 234 (1976); *See also United States v. Mendenhall*, 446 U.S. 544, 551-52 n. 5 (1980); *Adickes v. S. H. Kress & Co.*, 398 U.S. 144, 147 n. 2 (1970); *Delta Air Lines, Inc. v. August*, 450 U.S. 346, 362 (1981) (question presented in petition but not in court of appeals is not properly before the Court).

REASONS FOR DENYING THE WRIT

I. PETITIONERS' ADVOCATED COMMON LAW VESTING RULE FOR RETIREE MEDICAL PLANS DOES NOT RAISE AN ISSUE REQUIRING THE COURT'S REVIEW.

A. There Is No Conflict Among the Courts of Appeals over the Application of a Common Law Vesting Rule to Retiree Medical Plans.

The Courts of Appeals are unanimous in their rejection of the common law vesting rule advocated by Petitioners. *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d. 488, 491 (2d Cir. 1988) ("Automatic vesting does not occur in the case of welfare plans"); *Anderson v. Alpha Portland Indus., Inc.*, 836 F.2d 1512, 1516 (8th Cir. 1988), *cert. denied*, 57 U.S.L.W. 3565 (U.S. Feb. 27, 1989) (No. 87-2022) ("welfare benefits do not automatically vest as a matter of law"); *DeGeare v. Alpha Portland Indus., Inc.*, 837 F.2d 812, 815 (8th Cir. 1988), *vacated on other grounds*, 57 U.S.L.W. 3565 (U.S. Feb. 27, 1989) (No. 87-2070) (*Accord* with *Anderson v. Alpha-Portland Indus., Inc.*); *Anderson v. John Morrell & Co.*, 830 F.2d 872, 876 (8th Cir. 1987), (*Accord* with *DeGeare*); *Molnar v. Wibbelt*, 789 F.2d 244, 250 (3d Cir. 1986) ("Unlike rights to pension benefits, rights to welfare benefits do not automatically vest as a matter of law"); *In re White Farm Equip. Co.*, 788 F.2d 1186, 1193 (6th Cir. 1986) ("we discern no basis for finding mandatory vesting in ERISA of retiree welfare benefits"); *International Union, U.A.W. v. Cadillac Malleable Iron Co.*, 728 F.2d 807, 808 (6th Cir. 1984) ("we agree . . . that there is no legal presumption [of vested benefits] based on the status of retired employees"); *International Union, U.A.W. v. Yard-Man, Inc.* 716 F.2d 1476, 1479 (6th Cir. 1983), *cert. denied*, 456 U.S. 1007 (1984) ("[T]he court should first look to the explicit language of the collective bargaining agreement for clear manifestations of intent"); *Struble v. New Jersey Brewery Employees' Welfare Trust Fund*, 732 F.2d 325, 330-331 (3d Cir. 1984) (Collective bargaining agreement contained no language suggesting re-

tiree welfare benefits would continue beyond the life of the agreement; therefore, retirees are not entitled to vested lifetime benefits); *Turner v. Local Union 302 Int'l Bhd. of Teamsters*, 604 F.2d 1219, 1225, n. 5 (9th Cir. 1979) ("Pension plans must meet . . . vesting requirements . . . while welfare plans do not have to do so").

In the face of this overwhelming authority, Petitioners point to only two federal cases supporting their common law vesting rule; *In re Erie Lackawanna Ry*, 548 F.2d 621 (6th Cir. 1977) (applying Ohio law) and *In re White Farm Equipment Co.*, 42 Bankr. 1005. However, both of these cases arose in the Sixth Circuit and were overruled and reversed respectively by the Sixth Circuit's decisions in *In re White Farm Equipment Co.*, 788 F.2d 1186, 1192 (6th Cir. 1986) and in this case (Ptnr. Apx. A, A-18).

If Petitioners disagreed with the Court of Appeals' treatment of *In re Erie Lackawanna Ry.*, they should have petitioned for rehearing. They did not. The Supreme Court does not sit to resolve alleged inconsistencies between the decisions of a Court of Appeals or decide whether the Court of Appeals should have overruled one of its prior decisions. U.S. Sup. Ct. R. 17.1; *Davis v. United States*, 417 U.S. 333, 340 (1974).

B. Petitioners' Advocated Common Law Vesting Rule for Retiree Medical Plans Never Existed Before ERISA; Therefore, the Petition Raises No Question of a Conflict with ERISA.

1. No Pre-ERISA Case Gives Retired Employees the Right to Veto Modifications in Their Medical Plan Where the Employer Has Reserved the Right to Make Such Modifications.

Petitioners' argument for *certiorari* is founded on a superficially appealing syllogism. The first premise is that, under pre-ERISA law, Petitioners had a legal right to veto the changes in the medical plan sponsored by Respondents regardless of the plan's written terms. The second premise is that

ERISA is a remedial statute designed to expand the rights of employees. It follows, assert Petitioners, that the Court of Appeals' holding (the plan documents control) is in conflict with ERISA and the courts should establish an automatic vesting rule for medical benefits under ERISA.

However Petitioners' syllogism suffers from a critical flaw: there is not a single pre-ERISA case which has ever given a retired employee a vested interest in an employer sponsored medical plan in the face of an explicitly reserved amendment right in the governing plan documents.[11]

Indeed, none of the three pre-ERISA state law cases cited by Petitioners as evidence of their advocated medical benefits vesting rule even involved medical benefits.[12] To argue that retiree medical benefits could not be changed before ERISA regardless of the governing plan's terms based upon three state law cases, none of which even involved a medical plan, exceeds the bounds of reason and logic. The Supreme Court

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[11] Respondents have located only one pre-ERISA case (not cited by Petitioners) in which an employer was restrained from terminating or modifying a retiree medical plan. There, the Ohio Supreme Court held in a one-page *per curiam* affirmance that an employer could not terminate post-retirement medical coverage. *Sheehy v. Seilon, Inc.*, 227 N.E.2d 229 (Ohio 1967). However, there was no evidence that the employer had reserved the right to terminate coverage in *Sheehy*.

[12] *In re Erie Lackawanna Ry.*, 548 F.2d 621 (6th Cir. 1977) involved claims by former employees of a bankrupt employer for life insurance benefits. The court held the employees' claims were not entitled to administrative priority and the plan was terminated. Similarly, *Melin v. Northwestern Bell Tel. Co.*, 266 N.W.2d 183 (Minn. 1983) addressed whether an alcoholic was entitled to a disability pension under his employer's plan. The court held that alcoholism did not constitute a disability and denied recovery to the former employee. Finally, *Schlosser v. Allis-Chalmers Corp.*, 271 N.W.2d 879 (Wis. 1978) also involves the termination of a group life insurance plan. Life insurance and disability annuity benefits are distinguishable from medical benefits because the benefit liabilities are limited and readily ascertainable. See footnote 13 *infra*.

does not sit to review questions that are not raised by either the law or the facts.

2. Petitioners' Reliance on the Unilateral Contract Doctrine Applicable to Pension Plans Before ERISA is Inappropriate.

To bolster their claim of a conflict between the Court of Appeal's decision and ERISA, Petitioners have attempted to develop from pre-ERISA state law cases involving pension plans a fictitious legal doctrine applicable to medical plans. Petitioners cite *Hoefel v. Atlas Tack Corp.*, 581 F.2d 1 (1st Cir. 1978), *cert. denied*, 440 U.S. 913 (1979) as the leading case establishing that pre-ERISA law uniformly vested pension and medical benefits at retirement under the unilateral contract theory. Yet *Hoefel* is a case that deals exclusively with the termination of *pension* plans and the *Hoefel* court relied on ERISA in reaching its decision. Acknowledging that ERISA was inapplicable, the court nonetheless called ERISA "an expression of national policy" and held that its construction of state law was confirmed by:

> the concerns motivating Congress to enact ERISA in 1974 . . . *See* H. Rep.No. 93-807, 93d Cong., 2d Sess., 3 U.S. Code Cong. & Admin. News, pp. 4760, 4676 (1974); S. Rep. No. 93-127, 93d Cong., 2d Sess., 3 U.S. Code Cong. & Admin. News, pp. 4841-42 (1974).

Id. at 6.

Of course, as we see below, in enacting ERISA, Congress consciously chose for sound policy reasons to prescribe vesting rules, but to specifically exempt medical plans from the scope of the rules.[13] Thus, Petitioners assert the remarkable boot-

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[13] "Automatic vesting [of medical plans] was rejected because the costs of such plans are subject to fluctuating and unpredictable variables. Actuarial decisions concerning fixed [pension] annuities are based on fairly stable data, and vesting is appropriate. In contrast, medical insurance must take account of inflation, changes in medical practice and technology, and in-

strap argument that a pre-ERISA case decided in reliance on the policy choices made by Congress in enacting ERISA's *pension* vesting rules is evidence that pre-ERISA state law vested *medical* benefits.

C. Congress Consciously Chose to Reject Vesting of Retiree Medical Benefits Under ERISA and to Preempt State Law; Therefore, the Courts Are Not Free to Impose Vesting Requirements on Retiree Medical Plans.

Petitioners seem to think that this Court should grant *certiorari* simply because ERISA is a remedial statute and the Court of Appeals has denied their claims under ERISA. Petition pp. 12, 13. However, while ERISA generally expands the rights of employee benefit plan participants, its provisions reflect a careful balancing between the interests of participants and employee benefit plan sponsors.[14]

Congress enacted ERISA only after years of careful study. *Nachman Corp. v. P.B.G.C.*, 446 U.S. 359, 361-362 (1980); *Alessi v. Raybestos Manhattan, Inc.*, 451 U.S. 504, 510 (1981). Yet, there is no mention in ERISA's legislative history of the existence of Petitioner's alleged medical benefits vesting rule. It is preposterous to suggest, as Petitioners have, that Congress would overrule a "well-established" common law vesting rule without note or comment in the voluminous history of its deliberations and study in enacting ERISA.

However, even if Petitioners' mistaken assertion — that before ERISA medical benefits vested at retirement in some

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creases in the costs of treatment independent of inflation. These unstable variables prevent accurate predictions of future needs and costs." *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988).

[14] "If employers respond to more comprehensive coverage, vesting and funding rules by decreasing benefits under existing plans or slowing the rate of formation of new plans, little if anything would be gained from the standpoint of securing broader use of employee pensions and related plans." H. R. Rep. No. 807, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. Code Cong. & Admin. News 4670, 4682.

states regardless of the terms of any written plan — is correct, this case raises no unanswered federal question concerning the continued application of the rule after ERISA. Congress answered the question of whether medical benefits would be required by law to "vest" when it enacted ERISA § 201, 29 U.S.C. § 1051 (1982):

> This part [requiring vesting of "accrued benefits" under employee benefit plans and forbidding amendments which reduce vested "accrued benefits"] shall apply to any employee benefit plan described in section 4(a) (and not exempted under section 4(b)) *other than* —
>
> (i) an employee welfare benefit plan.[15] (Emphasis supplied).

H.R. Rep. No. 807 defines the accrued benefits which are required to vest under ERISA as follows:

> Under the committee bill, the vested employee is protected in his rights to all, or a certain percentage, of his "accrued benefit."
>
> * * *
>
> The term "accrued benefit" refers to pension or retirement benefits and is not intended to apply to certain ancillary benefits, such as medical insurance or life insurance, which are sometimes provided for employees in conjunction with a pension plan, and are sometimes provided separately.

H.R. Rep. No. 807, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. Code Cong. & Admin. News at 4726; *see also* H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. Code Cong. & Admin. News 5038, 5054.

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[15] Petitioners concede the post-retirement medical program at issue in this case is an employee welfare benefit plan. Petition, p. 5 n.5. *See*, ERISA § 3(1), 29 U.S.C. § 1002(1) (1982).

Thus, Congress explicitly considered and rejected the application of vesting requirements to employee welfare benefit plans. These explicit statements of legislative intent are a far cry from the Congressional "silence" alleged in the Petition (p. 13).

> '[U]nless this congressional intent can be inferred from the language of the statute, the statutory structure, or some other source, the essential predicate for implication of a private remedy simply does not exist.' *Northwest Airlines, Inc. v. Transport Workers*, 451 U.S. 77, 94 (1981). 'The federal judiciary will not engraft a remedy on a statute, no matter how salutary, that Congress did not intend to provide.' *California v. Sierra Club*, 451 U.S. 287, 297 (1981).

Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 145 (1985).[16]

Next, to eliminate any lingering doubts about the continued application of state common or statutory law to employee welfare and pension benefit plans, Congress declared any and all such state laws preempted by ERISA "... insofar as they may now or hereafter relate to any employee benefit plan ..."[17]

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[16] This Court has consistently rejected suggestions that it should disregard explicit statutory language to achieve some purpose deemed consistent with a perceived Congressional intent: "Judicial perception that a particular result would be unreasonable may enter into the construction of ambiguous provisions, but cannot justify disregard of what Congress has plainly and intentionally provided." *Commissioner v. Asphalt Prod. Co.*, 482 U.S. 117, 107 S.Ct. 2275, 2278 (1987); *Commissioner v. Gordon*, 391 U.S. 83, 93 (1968).

[17] There is no doubt that a state common law vesting rule would "relate to" a retiree medical plan within the meaning of § 514(a). *Metropolitan Life Ins. Co., v. Massachusetts*, 471 U.S. 724, 739 (1985) (state law requiring additional benefits not provided by a medical plan relates to the plan and is preempted unless saved by insurance law exception); *See also, Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983).

ERISA § 514(a), 29 U.S.C. § 1144(a) (1982).[18] Congress explained its preemptive intentions as follows:

> Finally, it is evident that the operations of employee benefit plans are increasingly interstate. The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.

S. Rep. No. 127, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. Code Cong. & Admin. News 4838, 4865.[19] *See also, Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. at 523 (state law indirectly requiring an ERISA plan to provide greater benefits than provided under the plan terms is preempted); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 96 (1983) (state human rights law is preempted; "[t]he breadth of § 514(a)'s pre-emptive reach is apparent from that section's language."); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 739 (1985) ("The pre-emption provision was intended to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA's substantive requirements."); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (state common law which would expand the relief obtainable by plan participants in ERISA suits is preempted); *Mackey v. Lanier Collection Agency & Service, Inc.*, 108 S.Ct. 2182, 2185 (1988) ("[W]e have virtually taken it for granted that state laws which are 'specifically

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[18] Exceptions to the broad preemptive scope of ERISA § 514(a) are provided for state insurance, banking, and securities laws. ERISA § 514(b), 29 U.S.C. § 1144(b) (1982). However, petitioners do not argue that their common law vesting rule arises under state insurance, banking, or securities laws and it is clear that none of the exceptions applies. *See, Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41. (State common law providing extra-contractual relief to ERISA plan participants is not saved by the insurance law exception).

[19] The legislative history of ERISA § 514(a) is succinctly recounted by the Court in footnotes 18, 19, and 20 of the Court's opinion in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 98-99.

designed to affect employee benefit plans' are pre-empted under § 514(a)").

Indeed, this Court has recognized that, while "ERISA imposes upon pension plans a variety of substantive requirements . . . [i]t does not regulate the substantive content of welfare-benefit plans." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 732. Instead, it reserves the determination of the substantive content of a welfare benefit plan for the plan sponsor. *Id.* at 739.[20]

Despite these explicit authorities, Petitioners ask this Court to grant their petition and determine whether pre-ERISA state common law from Minnesota, Wisconsin, and Ohio should be applied to regulate the substantive content of an ERISA medical program administered in Tennessee covering retirees in almost every other state. This is precisely the question Congress answered when it enacted § 514(a) and this Court has consistently rejected attempts to narrow the scope of § 514(a), especially when the state law at issue would impose requirements not contemplated by Congress.

Congress' answer to the question of whether medical benefits vest under ERISA or by operation of state law is crystal clear. They do not vest by operation of ERISA and any state law requiring such vesting is preempted; therefore, they vest, if at all, only by the express terms of the governing plan documents.[21] This, of course, is exactly what the Courts of

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[20] In *Metropolitan*, the Court held that a state law regulating the substantive content of a medical insurance program was "covered by ERISA's broad pre-emption provision set forth in § 514(a)." *Id.* at 739. The Court found the state law saved from preemption by the exception for laws regulating insurance. ERISA § 514(b) 29 U.S.C. § 1144(b) (1982). However, the insurance exception does not apply to Petitioners' common law vesting rule. *See* n. 18, *supra*.

[21] Congress emphasized the primacy of plan documents in determining a participant's entitlement to benefits under ERISA by requiring that employee benefit plans be maintained in writing (ERISA § 402(a) 29 U.S.C. § 1102(a) (1982)) and administered in accordance with their terms. ERISA

Appeals have held without exception and what the Court of Appeals held in this case. *See*, pp. 6, 7 *supra*, Ptnr. Apx. A, A-18, A-19. Therefore, the Court of Appeals' decision raises no important federal question requiring the Court's review.

II. THERE IS NO DISAGREEMENT AMONG THE CIRCUITS OVER THE PROPER CONSTRUCTION OF RETIREE MEDICAL PLANS.

Petitioners allege without any support that "[t]he Sixth Circuit's interpretation of the plan at issue in this case is inconsistent with that of other Circuits which have applied general insurance law to the interpretation of ERISA plans" Petition p. 9.[22] In fact, the Court of Appeal's approach to the plan documents in this case is in complete accord with the approach adopted by every other circuit which has been called upon to interpret a retiree medical program.[23]

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§ 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D) (1982). Ptnr. Apx. A, A-24-5. It would certainly be odd for Congress to include in ERISA's regulatory scheme the requirement that a written employee benefit plan "... provide a procedure for amending such plan ..." if Congress intended that the written procedure could be voided by the courts under state common law. ERISA § 402(b)(3).

[22] Petitioners also state "the Sixth Circuit expressly disapproved of the Third Circuit's actual application of the insurance law principles in [*Northeast Department ILGWU Health & Welfare Fund, Teamsters Local Union No. 229 Welfare Fund*, 764 F. 2d 147, (3d Cir. 1985)]." What the Sixth Circuit actually said was: "To the extent that dicta in the ILGWU decision suggest that escape clauses in single employer plans are automatically invalid, we respectfully disagree." (Ptnr. Apx. A, A-30). Even if this passing comment could be deemed "disagreement" it provides no support for the Petition because it is confined to an issue that has nothing to do with the plan interpretation challenged by Petitioners. Moreover the "escape clause" issue has long since become moot. "... Subsequent to entry of the order appealed from in this case ... the American General welfare plan was amended to eliminate the escape clause of which plaintiffs had complained..." (Ptnr. Apx. A, A-30).

[23] See the cases cited herein on pages 6 and 7. In fact, the Sixth Circuit has been accused of being more favorable to retirees than other circuits in its construction of retiree medical plans. *See Anderson v. Alpha Portland Indus.*,

Where then is the need to resort to state law? As the authorities cited by Petitioners clearly state, reference to state law is appropriate only when the state law is "compatible with national policy" and when "there is little federal law to which the court may turn for guidance." *Massachusetts Mut. Life Ins. Co. v. Russell,* 473 U.S. 134, 157, n. 18 (1985).

Here the opposite is true. In the face of an abundance of federal statutory and common law rejecting both their common law vesting rule and their artificial "reasonable expectations" construction rule, Petitioners point to only one decision which they claim applied the doctrine of reasonable expectations "... to limit policy provisions which, if read literally, would largely nullify an insurance policy ..." Petition, p. 11 citing *Van Orman v. American Ins. Co.,* 680 F.2d 301 (3d Cir. 1982). This statement is utterly baseless.

In *Van Orman*, the court ruled that, in view of its denial of the participants' claims, it could "assume, without deciding, that New Jersey [insurance] law controls." 680 F.2d at 308, *see also, id.* at 306.[24] The court went on to find the language of the governing (pension) plan documents controlling and rejected the participants' claims that the plan should be reformed to reflect their reasonable expectations.[25]

Indeed, when the *Van Orman* Court was called upon by the participants to adopt as federal common law under ERISA a

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Inc. 836 F.2d 1512, 1517 (8th Cir. 1988), *cert. denied*, 57 U.S.L.W. 3565 (U.S. Feb. 27, 1989) (No. 87-2022).

[24] Respondents are aware of no decision adopting under federal ERISA common law "the doctrine of reasonable expectations." The *Van Orman* court clearly declined to adopt the doctrine under ERISA.

[25] "As a matter of logic, we find it difficult to perceive how plaintiffs' expectations would be frustrated by the defendants' retention of the surplus if nothing in the booklets and letters led them to expect that a surplus might arise." *Van Orman,* 680 F.2d at 310.

rule that would override the written terms of the plan, it had this to say:

> We believe that Congress' authorization of the creation of a federal common law of pension plans must be considered in light of the comprehensive nature of the statute. Where Congress has established an extensive regulatory network and has expressly announced its intention to occupy the field, federal courts will not lightly create additional rights under the rubric of federal common law.
>
> * * *
>
> We are particularly reluctant to fashion a federal common-law doctrine of unjust enrichment when such a right would override a contractual provision.
>
> * * *
>
> The Supreme Court has emphasized the primacy of plan provisions absent a conflict with the statutory policies of ERISA.

Id. at 311-12.

In this case, the Court of Appeals devoted no less than thirteen pages (Ptnr. Apx. A, A-9 through A-21) of its thirty three page Slip Opinion to an exhaustive analysis of the numerous documents given to Petitioners describing the medical benefits program concluding:

> Nowhere in that or any other employee publication — or in any memorandum, letter, brochure, report, or other written document, as far as we have been able to ascertain after a careful search of the record — did the company ever promise any employee that all premiums for post-retirement medical coverage would be irrevocably "paid up" upon the employee's retirement. (*Id.*, A-21).

Application of the "doctrine of reasonable expectations" would yield exactly the same result as the Court of Appeals' decision in this case. Petitioners' request that this Court grant *certiorari* and uphold their "reasonable expectations" is simply a request to second-guess the Court of Appeals' conclusion based upon its unchallenged factual findings.

CONCLUSION

For the foregoing reasons, the Petition should be denied.

Respectfully submitted,

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APPENDIX

American General Corporation owns the following subsidiaries, which are involved in the joint ventures listed below:

AGC Resources, Inc.
- Highland Resources, Inc.

American General Investment Corporation
- Appelt Prop. No. 1, Ltd.

American General Life & Accident Insurance Company
- Charterhouse Mezzanine Fund, L.P.
- Fulcrum II, L.P.
- Fulcrum III, L.P.
- Institutional Venture Partners, L.P.
- Institutional Venture Partners, II, L.P.
- Morgan Stanley Leveraged Mezzanine Fund, L.P.

American General Life Insurance Company
- American General Health Club

American General Life Insurance Company of Delaware
- America Tower
- Cypress Crossing Venture
- Mosbacher — A.G. Company

American General Life Insurance Company of New York
- Highland Resources, Inc. 1984
- One Park Place Associates

American General Realty Investment Corporation
- American Avia Associates — KCI
- American Avia Associates — SEA
- American Avia Associates I
- American Fieldstone Venture
- American Newland Associates
- Boone-Southern
- Carlton Arms of Egypt Lake
- Charter Associates
- Cinco Ranch Venture
- Cutten Associates
- Cypress Associates
- Deer Valley Industrial Center

Glencairn Village
Hickory Downs Venture
Hickory Holly Venture
Hope Valley Venture
Jackrabbit Venture
Koll/Intereal Phoenix
Langham Associates
The Meadows Venture
Newmarket Venture
One Arlington Center
Pebble Creek Associates
Pecan Grove Associates
Sammis Diamond Bar II
Sammis Diamond Bar III
Treaschwig Associates
West Georgia Commons Associates

California-Western States Life Insurance Company
America Tower
Cal-Mira Mesa, Ltd.
Cal-Sorrento, Ltd.
Sunrise Mall Associates
Vagabond Glendale Motor Hotel
Vagabond Sunnyvale Motor Hotel
Warburg-Pincus LTD.

Georgetown Realty, Inc.
Lake Wylie

Gulf Equities
Parklawn Center
Shirley Industrial

Gulf Village, Inc.
Wharfside II

GULFCO Capital Management, Inc.
Soujourn/Westgrove Off/Serv Bldg.

Hadco, Inc.
Columbia Square
Duo Mercatum

Joventex Corporation
- Camino Real Apartments

Knickerbocker Corporation
- American Health Club Venture
- STEA Limited Partnership I

Life and Casualty Insurance Company of Tennessee
- Alamo II
- America Tower
- American General Health Club
- Blackstone Capital
- No. 1 Beach Street

Rylis Realty Company *
- Cinco Ranch Venture
- Columbia 205 Commerce Center
- Fairbanks Associates
- Glencairn Village
- Jackrabbit Venture
- Overlake Commercial Center
- Riverbrook Associates

Tennessee Vintage Corporation
- Vintage Faire Associates

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No. 88-1376

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

ROBERT L. MUSTO, *et al.*,
Petitioners,

vs.

AMERICAN GENERAL CORPORATION, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the
United States Court of Appeals for the Sixth Circuit

PETITIONERS' REPLY BRIEF AND SUPPLEMENTAL BRIEF

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PETITIONERS' REPLY BRIEF AND SUPPLEMENTAL BRIEF

Petitioners (hereinafter referred to as "the Retirees") submit this Reply Brief and Supplemental Brief in light of this Court's recent decision in *Firestone Tire and Rubber Co. v. Bruch,* 109 S. Ct. 948 (1989), and in response to the arguments raised in Respondents' Brief in Opposition.

I. THIS COURT HAS RECENTLY RECOGNIZED THAT ERISA WAS NOT INTENDED TO STRIP RETIREES OF PREEXISTING CONTRACT RIGHTS.

On February 21, 1989, this Court issued its opinion in *Firestone Tire and Rubber Co. v. Bruch,* 109 S. Ct. 948 (1989).

This decision was not available to the Retirees before they filed their Petition, but was available to Respondents before they filed their Brief in Opposition. Understandably, Respondents chose not to mention the significance of the *Firestone* case.

Firestone, as does the *Musto* case, involved unfunded employee welfare benefit plans. The issue in *Firestone* was whether an ERISA[1] plan administrator's decision to deny benefits was subject to a *de novo* or an arbitrary and capricious standard of review. Although the lower courts had adopted the arbitrary and capricious standard, this Court held that the *de novo* standard was the correct standard of judicial review.

Initially, the Court observed that although ERISA is a "comprehensive and reticulated statute," it does not address all issues in interpreting plans. 109 S. Ct. at 953 (citation omitted). In reaching its decision, the Court relied upon the state of the law before the enactment of ERISA. This Court sought a decision that was "consistent with the judicial interpretation of employee benefit plans prior to the enactment of ERISA." 109 S. Ct. at 955. Respondents have criticized the Retirees for relying upon contract law in support of their claim. (Resp. Brief in Opposition, pp. 9-10.) Yet, in *Firestone* the Court acknowledged that "[a]ctions challenging an employer's denial of benefits before enactment of ERISA were governed by principles of contract law." 109 S. Ct. at 955. In *Firestone,* the employer argued for a position that would have resulted in "less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." 109 S. Ct. at 956. The Court rejected this argument after reemphasizing that "ERISA was enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans,' and 'to protect *contractually* defined benefits'." 109 S. Ct. at 955 (citations omitted, emphasis added).

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[1] The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.*

The Retirees have sought review of this case to determine whether ERISA strips retirees of pre-ERISA rights concerning the interpretation of welfare benefit plans. In *Firestone,* this Court upheld the principle that ERISA was not designed to deprive beneficiaries of welfare benefits they enjoyed before ERISA. Yet this is exactly the position Respondents seek to impose upon the Retirees and every other retired person in this country who is covered by an employer-sponsored welfare benefit plan. Although Respondents disagreed with or mischaracterized nearly every assertion made in the Petition, Respondents did not deny that this Court has not previously provided guidance to the lower courts about how ERISA plans should be interpreted. (Petition, p. 9.) In *Firestone,* the principle that ERISA was not designed to afford less protection to welfare plan beneficiaries was limited to the issue of standard of review. The Court should grant review of the case at bar to extend this principle to the actual interpretation of plan documents. Otherwise, the standard of review mandated by this Court's *Firestone* decision will become a form without substance.

II. RESPONDENTS' BRIEF IN OPPOSITION MISCHARACTERIZED THE ISSUES PRESENTED FOR REVIEW.

In large part, Respondents use their Brief in Opposition to set up straw-man issues. Predictably, Respondents then do an excellent job of knocking down these straw men. Respondents, however, failed to address the issues raised in the Petition, issues that are of concern to thousands of retired persons and issues that this Court has suggested should be resolved in favor of the Retirees.

Respondents have claimed that the Retirees are seeking to have this case decided on the basis of state law. (Resp. Brief in Opposition, pp. 12-15.) There is no question that ERISA preempts state law control of employee benefit plans. Federal

common law must fill the void left by preemption. 109 U.S. 954. This federal common law should be based on the teachings of existing state law. *Massachusetts Mut. Life Ins. Co. v. Russell,* 473 U.S. 134, 157 (1985) (Brennan, J., concurring). Petitioners ask not that their case be decided on preempted state law, but that this Court determine what the federal substantive common law will be.

Contrary to Respondents' assertions, before the enactment of ERISA, the law was well settled that offers of post-retirement benefits could not be withdrawn after the employee had fully performed his end of the bargain by working until retirement. Every jurisdiction that considered the issue reached this conclusion. *E.g., Hoefel v. Atlas Tack Corp.,* 581 F.2d 1, 4-5 (1st Cir. 1978), *cert. denied,* 440 U.S. 913 (1979); *In re Erie Lackawanna Ry.,* 548 F.2d 621 (6th Cir. 1977).[2] Respondents cited not one pre-ERISA case contrary to this conclusion. Rather, Respondents have sought to distinguish this well-established body of pre-ERISA law on the grounds that most of these cases did not involve welfare benefits. There are certainly differences between medical and other benefits. These differences were well known to both the Retirees and the Respondents (or their predecessors in interest) at the time the Respondents accepted the many years of service the Retirees performed in reliance upon the offer of retiree medical insurance. The fact that retiree medical insurance is a less definite form of consideration than pension benefits was a risk that both parties accepted. The form of consideration does not alter the enforceability of the contract.

Respondents have suggested that "the courts are not free to impose vesting requirements on retiree medical plans." (Resp. Brief in Opposition, p. 10.) The Retirees agree with this state-

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[2] Because pre-ERISA case law was consistent across the country, this case is not, as Respondents have suggested, merely an inconsistency in Sixth Circuit decisions.

ment. The Retirees only want the courts to *enforce* a vesting requirement the parties imposed upon themselves. Respondents also cite a lengthy list of cases for the proposition that there is no "automatic vesting" of welfare plans under ERISA. The Retirees do not seek "automatic vesting." What they seek is an interpretation of the plan documents consistent with pre-ERISA law, which in this case would provide the Retirees with vested benefits.

Likewise, Respondents mischaracterize this action by stating that the Retirees seek to "veto" reductions and terminations of medical insurance. The Retirees no more seek to "veto" a change in the terms of their medical insurance than any party to a contract seeks to "veto" a breach of the contract.

Respondents have recast the issue in this case as whether the written plan document will be the primary determinant of the rights of the beneficiaries. (Resp. Brief in Opposition, p. i.) That simply is not the issue of this case. The issue is how should these written plan documents be interpreted. Before ERISA, the plan documents in question would have prohibited Respondents' reduction and termination of benefits for those persons who had retired. Congressional silence with respect to the vesting of welfare benefits cannot be interpreted as congressional disapproval of the vesting of welfare benefits. *In re White Farm Equipment Co.*, 788 F.2d 1186, 1192 (6th Cir. 1986). Additionally, the plan documents do not say that benefits can be reduced or terminated after an employee has retired.[3] Respondents' assertion that the Sixth Circuit made "factual findings" to this effect mischaracterizes both the role of the court of appeals and the nature of its conclusions. The

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[3] Although there were changes in the program from time to time, in over forty years there were never any changes that had a retroactive effect of changing the medical program for anyone after he or she had retired. The Retirees clearly stated this fact in their Petition and Respondents did not deny it.

court of appeals simply reviewed the written documents in question and drew legal conclusions as to how the documents should be interpreted.

Finally, Respondents stated that the Retirees did not raise before the court of appeals the issue of reasonable expectations under ERISA. This is entirely incorrect.[4] Respondents may have forgotten this portion of the Retirees' Sixth Circuit brief because the court of appeals did not address this substantial issue. Nor is the concept of reasonable expectations antithetical to ERISA. Indeed it has been relied upon in many ERISA cases. *E.g., Darden v. Nationwide Mut. Ins. Co.*, 796 F.2d 701, 706 (4th Cir. 1986) (employer who creates reasonable expectation of benefits must provide those benefits, particularly when the beneficiaries remained in the employer's service for many years); *Rettig v. Pension Benefit Guar. Corp.*, 744 F.2d 133, 153 (D.C. Cir. 1984) (employees with many years of employment with the employer have "reasonable expectation" of benefits); *A-T-O, Inc. v. Pension Benefit Guar. Corp.*, 634 F.2d 1013, 1020 (6th Cir. 1980) (ERISA should be interpreted so as to protect "employees' expectations"); *Pension Benefit Guar. Corp.*

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[4] In alleging that the Retirees "distort[ed] the record," (Resp. Brief in Opposition, p. 2, n. 5), the Respondents have done exactly that. Respondents' suggestion that they did not require medical insurance contributions in amounts greater than some of the Retirees' pensions (Resp. Brief in Opposition, p. 2, n. 5) is false. Emily Bottiggi, Respondents' own witness, clearly testified to this effect and there was no other evidence on this issue. Although Ms. Bottiggi's testimony is not part of the Appendix presently before the Court, it is a part of the record this Court would review if certiorari is granted. Moreover, although the district court could not tell at that time how many retirees had not enrolled in Respondents' reduced medical plan because the cost was prohibitive, the court indicated that there were some Retirees in this category. (App. B, A-46.) Also, the district court placed quotation marks around the word "chose" to indicate that the Retirees who did not have a pension large enough to pay for Respondents' medical program effectively had no choice but to decline Respondents' medical plan. (App. B, A-46.)

v. Heppenstall Co., 633 F.2d 293, 301 (3d Cir. 1980) (court considered "employee expectations" and allowed termination of plan where employees had no "justifiable expectation.") The doctrine of reasonable or justifiable expectations should be applied to this ERISA case of retiree medical benefits.

CONCLUSION

In *Firestone Tire and Rubber Co. v. Bruch,* this Court held that ERISA benefit plans should not be subjected to a standard of review that provided beneficiaries with less than they would have had before the enactment of ERISA. This Court should grant certiorari in this case to establish that ERISA benefit plans should not be interpreted to provide beneficiaries with less than they would have had before ERISA was enacted.

Respectfully submitted,

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